Date Posted: 4/24/2017 3:32:40 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

BUSINESS ADDRESS	Haber Dermatology, Inc 26949 Chagrin Blvd #300 Beachwood, OH 44122 Cuyahoga County United States (216) 932-5200 awahby@haberderm.com
CREDENTIAL MAIL ADDRESS	Haber Dermatology, Inc 26949 Chagrin Blvd. #300 Beachwood, OH 44122 Cuyahoga County United States (216) 932-5200 awahby@haberderm.com
MAIN	Haber Dermatology, Inc 26949 Chagrin Blvd #300 Beachwood, OH 44122 Cuyahoga County United States (216) 932-5200 awahby@haberderm.com

License Information

License Number	34.011998
License Name	Aziza Wahby

Fees

Relicensure Fee	$305.00
	========
Total Fees	**$305.00**

. 0

Medical Board Correspondence Email

1. **Did you provide a Credential email address? Please note this information is a public record.**

. . . . . YES

Specialty Codes

1. Please select one specialty from the field below

. . . . . DERMATOLOGY

2. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

3. Please select one specialty from the field below, if applicable.

. . . . . *{not Answered}*

CME-Physicians

1. Have you met the above CME requirements for your license?

. . . . . YES

Discipline

1. **At any time since signing your last application for renewal of your certificate** have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. **At any time since signing your last application for renewal of your certificate** have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. **At any time since signing your last application for renewal of your certificate** have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?

. . . . . NO

4. **At any time since signing your last application for renewal of your certificate** has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. **At any time since signing your last application for renewal of your certificate** have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons **other than failure to maintain records on a timely basis or to attend staff meetings?**

. . . . . NO

6. **At any time since signing your last application for renewal of your certificate** have you been addicted to or dependent upon alcohol or any chemical substance; relapsed, been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

Nurse Collaboration Info

1. Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?

. . . . . YES

2. List the name/names and type of licensure for each nurse with whom you are collaborating. **For example: Jane Doe, CNP; Mary Smith, CNS.**

. . . . . Mary Hylton, CNP

Ohio Employment

1. Do you practice in Ohio?

. . . . . YES

Ohio Workforce Questions

1. "Clinical" - direct patient care

. 45-49

2. "Research" - study of a treatment, procedure or medication done in a medical setting or for a medical purpose

. 5-9

3. "Administration" - activities related generally to patient care other than direct contact with a patient (e.g. recordkeeping, clerical tasks, chart review, prior authorizations with insurers, claims, billing issues, etc.)

. 1-4

4. "Education" - preceptor, mentor, etc.

. 1-4

5. "Volunteering" - providing medical and medical-related services at no cost

6. "Other" - medical professional activities not included in above categories

. 0

Clinical - Practice setting

1. Enter the number of hours per week spent in "Office/Clinic/Ambulatory care" (out-patient care).

. 45-49

2. Enter the number of hours per week spent in "Hospital (in-patient care)".

. 1-4

3. Enter the number of hours per week spent in "Emergency Room".

. 0

4. Enter the number of hours per week spent in "Urgent Care".

. 0

5. Enter the number of hours per week spent in "Other".

. 0

Workforce Counties

1. Enter the first zip code:

. 44122

2. Enter the first county:

. . . . . Cuyahoga

3. Enter the second zip code:

. 44060

4. Enter the second county:

. . . . . Lake

5. Enter the third zip code:

. . . . . *{not Answered}*

6. Enter the third county:

. . . . . *{not Answered}*

7. Do you have more than one practice location?

. . . . . YES

Workforce Practice Address

1. Please list all practice locations. Include street address, city, state and zip. Example "123 E Main St, Suite 2, Anywhere, OH 55555;" Separate multiply addresses with a semicolon.

. . . . . 26949 Chagrin Blvd #300 Beachwood, OH 44122, 7200 Mentor Ave Mentor Oh 44060

Practice Arrangement (size)

1. Solo practitioner

. . . . . NO

2. Single-specialty Group

. 2-5

3. Multi-specialty Group

. . . . . N/A

4. Employee of a clinical facility or hospital? (Clinical facility is an urgent care, industrial clinic or similar entity)

. . . . . NO

Workforce Language Question

1. Do practitioners or staff in your practice communicate in sign language or in a language other than spoken English?

. . . . . NO

ABMS Certified

1. Are you certified by an ABMS Board?

. . . . . NO

ABMS Specialty

1. Choose specialty from the dropdown list.

. . . . . Dermatology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

AOA Certified

1. Are you certified by an AOA Board?

. . . . . YES

AOA Specialty

1. Choose specialty from the dropdown list.

. . . . . Dermatology

2. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

3. Choose specialty from the dropdown list.

. . . . . *{not Answered}*

NPI number

1. Please enter your current NPI number.

. 1033474598

DEA number

1. Please enter your DEA number

. . . . . FW5888423

OARRS Registration

1. Since signing your last renewal have you prescribed or personally furnished opioid analgesics or benzondiazepines while practicing in Ohio?

. . . . . YES

2. Are you registered with the Ohio Automated Rx Reporting System (OARRS)?

. . . . . YES

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Submission Date and Time: 8/27/2019 3:01 PM

License Renewal Application

License Type - Doctor of Osteopathic Medicine (DO)

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio. If you do not have an Individual Provider Identifier (NPI) number please enter nine zeroes.

Title
Dr.
First Name
Aziza
Middle Name
Alexia
Last Name
Wahby
Maiden Name
No Response
Social Security Number
Redacted
Date of Birth
4/9/1980
Email Address
azizawahby@gmail.com
Phone Number
(515) 574-9238
Other Phone Number
(515) 574-9238
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language
No Response
Individual National Provider Identifier - if N/A enter all zeroes
1033474598
Enter home US zip-code. Enter NA if unavailable
44120

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?
No Response
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
New York
In which city were you born?
New York

Employment Status

Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

What is your primary employment status
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Maintain practice hours as is

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

2971 Paxton Rd
Shaker Heights
OH
44120-1823
United States

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

4350 Crocker Rd Ste 300
Westlake
OH
44145-6329
United States

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
If you answered "Yes", are you currently serving in the military?
No
Has your spouse served in the military?
No
If you answered "Yes", are they currently serving in the military?
No
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:

Specialty Tracking Component

Please list any American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education specialty and/or subspecialty certifications that you currently hold.

Medical Speciality Certification - American Osteopathic Association (AOA)
Medical Speciality - Dermatology (AOA)
Medical SubSpeciality - null

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position that requires this license (e.g. student or recent graduate) employment location information is optional. Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Name of Practice Site - Apex Dermatology Westlake
Practice Settings - Office/Clinic - Single Specialty Group
Street Address - 4350 Crocker Rd Ste. 300
City - Westlake
State - OH
Zip Code - 44145
Major Area of Focus or Specialty - Dermatology (AOA)
Total Hours Worked at this practice site, per Week - 36

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 100
Teaching/Academic - 0
Research - 0
Professional Services - 0
Administrative Activities - 0
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - No
Current Employment Arrangement - Salaried
Other Employment Arrangement - null
Intern/Resident Position - No
Employed as Federal Employee - No
Accepting New Patients - Yes

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue.

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - Yes

Question - Please provide the following information for up to 3 locations in which you use the license you are renewing, beginning with the locations you spend the most time: Facility Name, Address, City, State, Zip Code, Health Care Facility Type
Answer - Apex Dermatology Westlake, 4350 Crocker Rd, Ste 300 Westlake OH 44145

Question - Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
Answer - Yes

Question - At any time since signing your last application for renewal of your certificate have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
Answer - No

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - No

Question - At any time since submission of your last application for renewal have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer NO to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer YES if you have ever relapsed.
Answer - No

Question - At any time since signing your last application for renewal of your certificate has any board, bureau, department, agency, or any other body, including those in Ohio other than this board, filed any charges, allegations or complaints against you?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you had any clinical privileges or other similar institutional authority suspended, restricted, revoked or placed on probation for reasons other than failure to maintain records on a timely basis or to attend staff meetings?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you ever been denied a license to prescribe, dispense, administer, supply, or sell a controlled substance by the drug enforcement administration or appropriate issuing body of any state or jurisdiction, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying or selling a controlled substance or other dangerous drug?

Answer - No

Question - At any time since signing your last application for renewal of your certificate have you ever had a restriction of a license issued by the drug enforcement administration or a state licensing administration in any jurisdiction, under which you could prescribe, dispense, administer, supply or sell a controlled substance, that was restricted, based, in whole or in part, on inappropriate prescribing, dispensing, administering, supplying, or selling a controlled substance or other dangerous drug?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you ever been subject to disciplinary action by any licensing entity that was based, in whole or in part, on inappropriate prescribing, dispensing, diverting, administering, supplying or selling a controlled substance or other dangerous drug?
Answer - No

Question - Have you completed at least two hours of continuing medical education, annually for the past two years, that were certified by the Ohio State Medical Association or the Ohio Osteopathic Association, that assist physicians in diagnosing qualifying medical conditions and treating these conditions with medical marijuana including the characteristics of medical marijuana and possible drug interaction.
Answer - Yes

Question - At any time since signing your last application for renewal of your certificate do you have an ownership or investment interest in or compensation agreement with any medical marijuana entity or applicant?
Answer - No

Question - Do you currently supervise one or more Physician Assistants?
Answer - No

Question - Do you prescribe controlled substances?
Answer - Yes

Question - Primary DEA Number
Answer - FW5888423

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

Title - DEA Registration
Description - I have an active registration with the Drug Enforcement Administration (DEA).
Attested - Attestation complete

Title - OARRS Registration
Description - I attest that I hold registration to check the drug database (OARRS) established and maintained by the board of pharmacy.
Attested - Attestation complete

Title - Continuing Education
Description - Attach a copy of all relevant Continuing Education for the Certificate to Recommend

Attached file - 46E4B509-4F0A-4183-A97E-5DA98F03DDA2.jpeg

Attached file - 928F1D6F-9EA3-47B7-9D60-907E7D41BB6D.jpeg

Review + Submit

Once the review has been processed, the license application will be completed.

Application Review - Completed

Attestation
I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license. Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying.

Consent to Electronic Signature - **Consented**
Date/Time Stamp - 8/27/2019 3:01 PM
Type your First Name and Last Name as they appear on the application to sign electronically.
Aziza Wahby
Submit your Application -After clicking the ‘Submit’ button below, you will no longer be able to change this

application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in. If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.

Submission Date and Time: 8/4/2021 10:21 AM

License Renewal Application

License Type - Doctor of Osteopathic Medicine (DO)

License Number - 34.011998CTR

License Renewal Number - LR-004291787

Personal Information

Provide the necessary personal information in the fields to the right. All fields with (*) are required and must be completed to continue the application process. Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio. If you do not have an Individual Provider Identifier (NPI) number please enter nine zeroes.

Title
Dr.
First Name
Aziza
Middle Name
Alexia
Last Name
Wahby
Maiden Name
No Response
Social Security Number
Redacted
Date of Birth
4/9/1980
Email Address
azizawahby@gmail.com
Phone Number
(515) 574-9238
Other Phone Number
(515) 574-9238
What is your U.S. Residency status related to your employment?
United States Citizen
Do you consider yourself Hispanic, Latino/a or of Spanish origin?
No
What do you consider your race?
White
List languages you personally use to communicate with patients excluding an interpreter or software
English
Other Language

No Response
Individual National Provider Identifier - if N/A enter all zeroes
1033474598
Enter home US zip-code. Enter NA if unavailable
44120

Additional Information

Provide the necessary additional information in the fields to the right. All fields with (*) are required and must be completed to continue the application process.

Do you have other aliases?
No Response
What is your gender?
Female
In which country were you born?
United States
In which state were you born (if United States)?
New York
In which city were you born?
New York

Employment Status

Demographic and workforce data collected for some licensed healthcare professions is used to enhance the state's capacity for healthcare workforce forecasting, policy development, and research. This data is used to analyze the supply and demand of the healthcare workforce serving Ohio.

What is your primary employment status
Actively working in a position(s) that requires this license
Which of the following best describes your five-year employment plan?
Maintain practice hours as is
Are you currently employed outside of USA?
No

License Mailing Address

Select a license mailing address by clicking the appropriate checkbox to the right (this is the address used for all postal communications from the Board for this license). To add a new address, click Add Address, complete the required fields, and click Save.

2971 Paxton Rd
Shaker Heights
OH
44120-1823
United States

License Public Address

Select a public license mailing address by clicking the appropriate checkbox to the right (this is the address that will be viewable by the public). To add a new address, click Add Address, complete the required fields, and click Save.

4350 Crocker Rd Ste 300
Westlake
OH
44145-6329
United States

Military Service

If you have served in the military, provide the information for the type of service and duration of the service. Also, provide proof of your service.

Have you served in the military?
No
If you answered "Yes", are you currently serving in the military?
No
Has your spouse served in the military?
No
If you answered "Yes", are they currently serving in the military?
No
I declined to answer these questions

Secondary Email Recipient

You may define another email recipient for all automated emails you receive related to your license. You may change this recipient at any time from your dashboard.

Secondary Email Address:

Specialty Tracking Component

Please list any American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education specialty and/or subspecialty certifications that you currently hold.

Current Employment Location(s)

Please provide the following information for all practice sites where you use this license, beginning with the locations in which you spend most of your time. If you are not actively working or volunteering in a position that requires this license (e.g. student or recent graduate) employment location information is optional. Employment location information helps improve the accuracy and efficiency of Health Professional Shortage Area Designations and enables Ohio to identify healthcare workforce distribution.

Name of Practice Site - Apex Dermatology
Practice Settings - Office/Clinic - Single Specialty Group
Street Address - 6820 Ridge Rd
City - Parma
State - OH
Zip Code - 44129
Major Area of Focus or Specialty - Dermatology (AOA)
Total Hours Worked at this practice site, per Week - 35

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 100
Teaching/Academic - 0
Research - 0
Professional Services - 0
Administrative Activities - 0
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - No
Current Employment Arrangement - Salaried
Other Employment Arrangement - null
Intern/Resident Position - No
Employed as Federal Employee - No
Accepting New Patients - Yes

Name of Practice Site - Louis Stokes Wade Park Veterans Hospital
Practice Settings - Hospital - Ambulatory Care Center
Street Address - 10701 East Blvd
City - Cleveland
State - OH
Zip Code - 44106
Major Area of Focus or Specialty - Dermatology (AOA)
Total Hours Worked at this practice site, per Week - 4

Percent of time spent per week in each of the following at this practice site:
Direct Patient Care - 50
Teaching/Academic - 50
Research - 0
Professional Services - 0
Administrative Activities - 0
Other - 0
Total Hours- 100

Hospital Admitting Privileges for Patients - Yes
Current Employment Arrangement - Contractual
Other Employment Arrangement - null
Intern/Resident Position - No
Employed as Federal Employee - Yes
Accepting New Patients - Yes

Questions

Answer the following questions by selecting the Yes/No option for each question. Once completed, click Save and Continue. For any question that is answered in the affirmative you will later be required to upload a detailed explanation and supporting documents.

Question - Would you like to renew your certificate to recommend medical marijuana?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, disciplined, or have had any charges, allegations or complaints filed against you, by any board, bureau, department, agency, or any other body, including those in Ohio?
Answer - No

Question - At any time since submission of your last application for renewal have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse? You may answer NO to this question if you have successfully completed treatment at, or are currently enrolled in, a program approved by this Board and have adhered to all statutory requirements during and subsequent to treatment. You must answer YES if you have ever relapsed.
Answer - No

Question - At any time since signing your last application for renewal of your certificate have you had admissions monitored, had clinical privileges or other similar institutional authority limited, restricted,

suspended, revoked, terminated, or placed on probation for any reason, or have resigned privileges at any institution?
Answer - No

Question - At any time since signing your last application for renewal of your certificate have any malpractice awards been paid by you or on your behalf for acts occurring in any state other than Ohio?
Answer - No

Question - Do you currently supervise one or more Physician Assistants?
Answer - No

Question - Are you currently in a collaboration agreement with any Clinical Nurse Specialists, Certified Nurse-Midwives or Certified Nurse Practitioners?
Answer - No

Question - Are you one of the following: a medical director of an emergency medical service organization, a physician member of an advisory board of an emergency medical service organization, an employee of the State of Ohio, an employee of the Department of Corrections and have or have had contact with inmates and persons under supervision, or an employee of the Department of Youth Services? An affirmative answer to this question provides notice to the board that your residential and familial information is exempt from disclosure under Ohio's public records laws. Failure to self-identify may result in the board releasing such information in response to public records requests. In the event that your answer to this question changes before your next license renewal, you should immediately notify the board.
Answer - No

Question - Do you prescribe controlled substances?
Answer - Yes

Question - Primary DEA Number
Answer - FW5888423

Question - At any time since signing your last application for renewal of your certificate have you been investigated, warned, censured, put on probation, terminated, or disciplined by any employer, hospital, group practice, nursing home, clinic, health maintenance organization, or other similar institution, for any reason?
Answer - No

Question - Are you registered with the Ohio Automated Rx Reporting System (OARRS)?
Answer - Yes

Question - Since signing your last renewal have you prescribed opioid analgesics or benzondiazepines while practicing in Ohio?
Answer - Yes

Question - At any time since signing your last application for renewal of your certificate, have you engaged in conduct prohibited by the Medical Board’s rules regarding sexual misconduct and impropriety (chapter 4731-26 of the Administrative Code)?
Answer - No

Attachments

If applicable, upload the Attachments for your license application by clicking the Add Attachment button(s). Attachments related to affirmative answers must include a detailed explanation and supporting documentation. If uploading an attachment as a submission, it is necessary that the name of the file attachment is less than 80 characters in length for it to be received successfully. The character limit does include the file attachment extension, such as (.doc) and (.pdf). The (.exe) and (.html) file extensions are not supported for submissions. For documentation that needs to be submitted directly to the Board or by hardcopy, please acknowledge by clicking the Attest button(s). If no attachment or attestation items appear, please click the Save and Continue button.

Title - CTR non-renewal attestation
Description - I acknowledge that I do not want to renew my certificate to recommend
Attested - Attestation complete

Review + Submit

Once the review has been processed, the license application will be completed.

Application Review - Completed

Attestation
I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license. Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying.

Consent to Electronic Signature - **Consented**

Date/Time Stamp - 8/4/2021 10:21 AM
Type your First Name and Last Name as they appear on the application to sign electronically.
Aziza Wahby
Submit your Application -After clicking the ‘Submit’ button below, you will no longer be able to change this application. **PLEASE DO NOT USE THE BROWSER'S BACK BUTTON AS THAT MAY OVERWRITE YOUR DATA.** If you want to return to your application, simply log out and log back in.
If this application requires payment you will be prompted to begin the payment process. You must complete the payment process before the board will review your application. If this application does not require payment, you will be navigated back to the eLicense home page and the board will review your application.

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

This report provides credentialing information for

Name: **Aziza Alexia Wahby**

Social Security Number: **XXX-XX-**[Redacted]

Date of Birth: **April 09, 1980**

FID#: **301127346**

Recipient: **OH - State Medical Board of Ohio**

ABOUT THIS PROFILE

The Federation Credentials Verification Service (FCVS) was retained by the above referenced medical professional to verify his/her medical credentials for submission to your agency/organization. Unless noted otherwise, all documents contained in this report were received directly from the issuing institution per written request made by FCVS.

NOTICE: All documents bearing an original Official FCVS seal are certified to be an exact reproduction of the original. Where required, original documents are provided according to the agreements with the Institution issuing such document. FCVS maintains all original documents (excluding third-party examination transcripts) in the physician's source file.

This FCVS Medical Professional Information Profile ("Profile") is compiled and provided by the Federation of State Medical Boards of the United States, Inc. (Federation) as a reference source for, and only for, its member boards and other entities authorized by the Federation. The Profile embodies and contains confidential business information because the information, and the format and presentation of that information, comprise trade secrets of the Federation and because the Profile's disclosure would harm the Federation by providing others with an unfair business advantage in competing with the Federation's FCVS services. Further, the form of the Profile and the contents of this Profile, including the compilation of information in this Profile, are the Federation's copyrighted works and proprietary, confidential information and are subject to the protections of United States laws governing copyright, trademark and trade secrets, as well as various state laws protecting the Federation's trade secrets and other intellectual property rights. This Profile and its contents may not be (1) copied, reformatted, modified, published or displayed publicly or (2) used, disclosed, distributed, shared or sold, in whole or part, for any purpose, including use to establish any database or files as a compendium or otherwise, all of which is strictly prohibited without the express written consent of the Federation's CEO.

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 **TEL**(817)868-5000 **FAX**(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Summary Report

Federation of STATE MEDICAL BOARDS

Note: *Your board may wish to review the unresolved items below marked by an "X"*
Please review the Credentials Analysis Report for further details on the unresolved items

Medical Professional Name: **Aziza Alexia Wahby**
Date of Birth: **April 09, 1980**
Social Security Number: **XXX-XX-**[redacted]
FID: **301127346**

I. FCVS Reports

II. FSMB and Other Reports

III. Identity

A. Certified Birth Certificate OR Copy w/ Cert. of Identification

IV. Medical Education

A. Pre-medical Schools

B. Medical Schools

Touro College of Osteopathic Medicine
1. Medical Education Form and Translation
2. Medical Education Dean's Letter
3. Medical Education Transcript and Translation
4. Medical Education Diploma and Translation

C. Fifth Pathway Program

D. ECFMG Certification

V. Graduate Medical Education

NSUCOM/Largo Medical Center
1. GME Form
2. GME Completion Certificate

University Hospitals of Cleveland
1. GME Form

VI. Licensure Examination History

A. NBOME Transcript

End of report for: Aziza Alexia Wahby

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

Table of Contents

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Profile

Federation of STATE MEDICAL BOARDS

Section I

FCVS Reports

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Medical Professional Information Report

Federation of STATE MEDICAL BOARDS

Identity

Medical Professional Name:	**Aziza Alexia Wahby**
	Documentation: Certified Birth Certificate OR Copy w/ Cert. of Identification
Gender:	Female
Date of Birth:	April 09, 1980
Place of Birth:	New York City, NY, UNITED STATES
Social Security Number:	XXX-XX-[redacted]
FID:	301127346
Physical Description:	Height: 5 ft. 6 in.
	Weight: 105 lbs.
	Eye Color: Brown
	Hair Color: Brown

Contact Information

Mailing Address:	2303 BELLFIELD AVE APT 1 CLEVELAND HEIGHTS, OH 44106-3158 UNITED STATES
Permanent Address:	2303 BELLFIELD AVE APT 1 CLEVELAND HEIGHTS, OH 44106-3158 UNITED STATES
Telephone Numbers:	Primary: (515) 574-9238
	Secondary: N/A
	Fax: N/A
	Other: N/A

Pre-medical Education

(Provided by Applicant. Not verified with the primary source.)

Institution: **The Cleveland Institute of Music**
Address: Cleveland, OH 44106
UNITED STATES
Dates of Attendance: 08/--/1997 To 05/--/2001
Degree Conferred/Issued: Bachelor of Arts

(Provided by Applicant. Not verified with the primary source.)

Institution: **The Cleveland Institute of Music**
Address: Cleveland, OH 44106
UNITED STATES
Dates of Attendance: 08/--/2001 To 05/--/2003
Degree Conferred/Issued: Master of Arts

(Provided by Applicant. Not verified with the primary source.)

Institution: **Columbia University**
Address: New York, NY 10027
UNITED STATES
Dates of Attendance: 08/--/2004 To 06/--/2008
Degree Conferred/Issued: Bachelor of Arts

ECFMG

There are none identified or not applicable.

Medical Education

Medical School:	**Touro College of Osteopathic Medicine**
Address:	2090 Adam Clayton Powell Blvd. 6th Fl New York, NY 10027 UNITED STATES
Dates of Attendance:	08/11/2008 to 05/30/2012
Date Certificate Issued:	06/26/2012
Degree Conferred/Issued:	Doctor of Osteopathic Medicine

Unusual Circumstances

Leave of Absence/Extension:	**No**
Probation:	**No**
Disciplined:	**No**
Negative Reports:	**No**
Limitations:	**No**

Fifth Pathway

There are none identified or not applicable.

Graduate Medical Education

Institution: **NSUCOM/Largo Medical Center**
Address: 2025 Indian Rocks Road

Largo, FL 33774
UNITED STATES

Training Level: 1
Program Type: Internship
Specialty: Traditional
Dates of Attendance: 07/01/2012 To 06/30/2013
Completed Successfully: Yes
Accreditation: AOA

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Institution: **University Hospitals of Cleveland**
Address: 11100 Euclid Avenue

Cleveland, OH 44106
UNITED STATES

Training Level: 2 - 3
Program Type: Residency
Specialty: Dermatology
Dates of Attendance: 07/01/2013 To 06/30/2015
Completed Successfully: Yes
Accreditation: AOA

Training Level: 4 - 4
Program Type: Residency
Specialty: Dermatology
Dates of Attendance: 07/01/2015 To 06/30/2016
Completed Successfully: In Progress
Accreditation: AOA

Unusual Circumstances
Leave of Absence/Extension: **No**
Probation: **No**
Disciplined: **No**
Negative Reports: **No**
Limitations: **No**

Licensure Examinations

NBOME - National Board of Osteopathic Medical Examiners NBOME - COMLEX Level 1	Date: 06/2010	Passed the Exam
NBOME - National Board of Osteopathic Medical Examiners NBOME - COMLEX Level 2 PE	Date: 06/2011	Passed the Exam
NBOME - National Board of Osteopathic Medical Examiners NBOME - COMLEX Level 2 CE	Date: 06/2011	Passed the Exam
NBOME - National Board of Osteopathic Medical Examiners NBOME - COMLEX Level 3	Date: 04/2013	Passed the Exam

Board Action

A report of the results from a search of the Board Action Data Bank is enclosed.

End of report for: Aziza Alexia Wahby FID: 301127346

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Credentials Analysis Report

Federation of STATE MEDICAL BOARDS

The Credentials Analysis Report is a comparative report of a medical professional's credentials as reported to FCVS by the applicant and the primary source (Medical School, Post Graduate Training program, etc.). It will also list particular missing documentation, if any, as outlined in the FCVS Policies and Procedures.

Medical Professional Identification

Medical Professional Name:	**Aziza Alexia Wahby**
Date of Birth:	**April 09, 1980**
Social Security Number:	**XXX-XX-**[redacted]
FID:	**301127346**

Omissions

There are no omissions identified.

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 **TEL**(817)868-5000 **FAX**(817)868-5099

Discrepancies

There are no discrepancies identified.

Miscellaneous Information

Miscellaneous 1:

Section of Profile:	**Personal Information**
Miscellaneous:	**The documented date of birth is 04/09/1980. The Graduate Medical Verification forms completed by both NSUCOM and University Hospitals of Cleveland indicate the date of birth is 04/19/1980.**
Action Taken:	**FCVS preprints the applicant`s date of birth on the verification form. This error was made when initiating the application and has been corrected in our system.**

End of report for: Aziza Alexia Wahby

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Chronology of Activities

Federation of STATE MEDICAL BOARDS

The Chronology of Activities is a comprehensive report of a medical professional's activities as reported to FCVS by the medical-professional applicant.

Medical Professional Name: **Aziza Alexia Wahby**
Date of Birth: **April 09, 1980**
Social Security Number: **XXX-XX-**[redacted]
FID#: **301127346**

Start Date	End Date	Activity	Location	Overlap Explanation	Program Length Explanation
08/2008	06/2012	Medical Education Record	Touro College of Osteopathic Medicine,2090 Adam Clayton Powell Blvd. 6th Fl New York, NY 10027 UNITED STATES		
07/2012	06/2013	GME Record	NSUCOM/Largo Medical Center,2025 Indian Rocks Road Largo, FL 33774 UNITED STATES		
07/2013	06/2016	GME Record	University Hospitals of Cleveland,11100 Euclid Avenue Cleveland, OH 44106 UNITED STATES		

End of report for: Aziza Alexia Wahby

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

Section II

FSMB and Other Reports

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

PDC PHYSICIAN DATA CENTER

Federation of STATE MEDICAL BOARDS

PRACTITIONER PROFILE

Prepared for: FCVS As of Date:9/4/2015

PRACTITIONER INFORMATION

Name:	Aziza Alexia Wahby
DOB:	4/9/1980
Medical School:	Touro University College of Osteopathic Medicine-New York New York, New York, UNITED STATES
Year of Grad:	2012
Degree Type:	DO

BOARD ACTIONS

To date, there have been no actions reported to the FSMB

LICENSE HISTORY

Jurisdiction	License Number	Issue Date	Expiration Date	Last Updated

400 FULLER WISER ROAD EULESS, TX 76039 | TEL(817)868 4000 | FAX (817)868 4099

PRACTITIONER PROFILE

Prepared for:	FCVS	As of Date:9/4/2015
Practitioner Name:	Aziza Alexia Wahby	

ABMS® CERTIFICATION HISTORY

No ABMS Certifications found.

Section III

Identity

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Affidavit and Release

Federation of STATE MEDICAL BOARDS

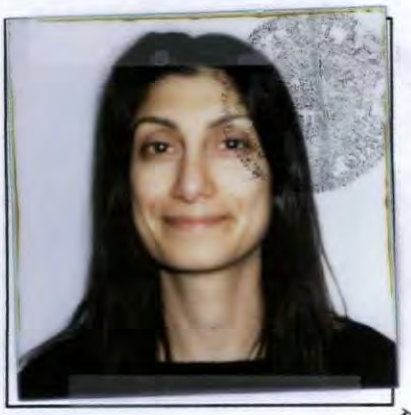
I, the undersigned, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to me being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Federation Credentials Verification Service any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Federation Credentials Verification Service or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

Notary:
Your seal (or stamp) must be partly upon the photo and partly upon the signature of the applicant.

I hereby release, discharge and exonerate the Federation Credentials Verification Service, its agents or representatives and any person furnishing information, of any and all liability of every nature and kind arising out of investigation made by the Federation Credentials Verification Service. I authorize the Federation Credentials Verification Service to release information, material, documents, orders or the like relating to me or this application to any entity at my request.



Applicant's Signature (must be signed in the presence of a notary)

Diamond Haynes
Notary Public, State of Ohio
My Commission Expires
August 21, 2019

Applicant's **Printed** Last Name

Aziza A

Applicant's **Printed** First Name, Middle Initial, and Suffix (e.g., Jr.)

5/18/15

Date of Signature (**must** correspond to date of notarization)

State of Ohio, County of Cuyahoga,

I certify that on the date set forth below the individual named above did appear personally before me and that I did identify this applicant by: (a) comparing his/her physical appearance with the photograph on the identifying document presented by the applicant and with the photograph affixed hereto, and (b) comparing the applicant's signature made in my presence on this form with the signature on his/her identifying document. The statements on this document are subscribed and sworn to before me by the applicant on this 18th day of May, 2015.

Notary Public Signature: Diamond Haynes

My Notary Commission Expires: 08/21/2019

Please complete and mail this original document to the Federation of State Medical Boards at:

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000

341174

CERTIFICATION OF IDENTIFICATION

Certification by Notary Public Is Required

RECEIVED
MAY 21 2015

Applicant Full Legal Name: Wahby (Last) Aziza (First) Alexia (Middle)

FCVS ID Number: 341174

Notary – Please complete the section below:

State of Ohio County of Cuyahoga

I certify that on the date set forth below, the individual named above, did appear personally before me and presented one of the following forms of identification as proof of his/her identity (Birth Certificate or Passport). I further certify that I did identify this applicant by comparing his/her physical appearance with the photograph on a Government issued photo identification presented by the applicant.

The statements on this document are subscribed and sworn to before me by the applicant on this (Day) 18th, of (Month) May, (Year) 2015.

Notary Public Signature: Diamond Haynes

Commission Expiration Date* (Month) 08 /(Day) 21 /(Year) 2019

*** The notary's commission expiration date must be current and legible. If no expiration date, such as 'lifetime', an explanation must be provided.**

Notary Stamp Here

NOTARIAL SEAL STATE OF OHIO
Diamond Haynes
Notary Public, State of Ohio
My Commission Expires
August 21, 2019

Please complete and mail this original document and a photocopy of the birth certificate or passport presented to the Notary to:

Federation of State Medical Boards
ATTN: FCVS
400 Fuller Wiser Rd., Suite 300
Euless, TX 76039-3856

341174 BC

341174

341174

VR 115 (Rev. 6/87) 9-922177-375M

DOCUMENT NO. E 390985

THE CITY OF NEW YORK

DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
CERTIFICATION OF BIRTH

This is a certification of name and birth facts on file in the Bureau of Vital Records, Department of Health, City of New York.

DATE OF BIRTH: APRIL 9, 1980

CERTIFICATE NO.: 156-80-308888

BOROUGH: BROOKLYN

DATE FILED: 04-15-80

DATE ISSUED: 01-14-91

NAME: AZIZA ALEXIA WAHBY ***

SEX: FEMALE

MOTHER'S MAIDEN NAME: MARY LOU BONVENTRI

FATHER'S NAME: SAMIR WAHBY

Irene A. Scanlon

IRENE A. SCANLON
CITY REGISTRAR

DEPARTMENT OF HEALTH ★ THE CITY OF NEW YORK ★ 1625

Do not accept this transcript unless it bears the raised seal of the Department of Health. The reproduction or alteration of this certification is prohibited by Section 3.21 of the New York City Health Code.

Section IV

Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Medical Education

Federation of STATE MEDICAL BOARDS

Instruction to the Dean

Please complete both pages of this form, sign date and seal on the front page then return to:

Federation Credentials Verification Service
400 Fuller Wiser Road
Suite 300
Euless, TX 76039

The individual identified on the attached Authorization for Release of Information, Documents and Records form has authorized your medical school to provide to the Federation Credentials Verification Service (FCVS) any and all information pertaining to their education at your institution.

Please note: If your institution processes transcript requests through another office, FCVS has likely made such a request under separate cover.

If your office also processes transcript requests, please attach the individual's official transcript (which indicates courses taken, dates and hours of attendance, and scores, grades, or evaluation).

Institution Name: Touro College of Osteopathic Medicine

Address Line 1: 230 West 125th

Address Line 2:

City: New York **State/Province:** NY **Zip Code (Postal Code):** 10027

Country: US

If name of institution was different when this individual attended, please note this name below:
N/A

Premedical Education:
Years of education required for admission to your medical school: 4
Credential/degree presented by the applicant for admission to your medical school: Bachelor's Degree

Enrollment and Participation: Our records indicate that Wahby, Aziza Alexia
(type/print individual's name: Last, First, Middle, Suffix)
attended our medical school for total of 4 years of medical education on the following dates: **From:** 08/11/2008 (Month Day Year) **To:** 05/30/2012 (Month Day Year)

This individual
Was awarded the degree of Doctor of Osteopathic Medicine on 06/26/2012 (Month Day Year)
Was NOT awarded a degree because: (please explain - additional page if necessary)

Attestation

Affix Institutional Seal Here

If no seal is available, this form must be notarized.

Watermark
For FCVS internal use only.

Name: Kendra Copeland

Signature: *Kendra Copeland*

Title: Associate Registrar
Date of Signature: 08/21/2015 **Phone:** (212) 851-1199
Fax: (212) 851-1183 **Email:** kcopeland@touro.edu

ELECTRONIC SEAL VERIFIED

64174 1570 301127346

Unusual Circumstances

1. Do this individual's official records reflect (an) interruption(s) or extension(s) in his/her medical education? **No**

If Yes, please specify the reason(s) for, indicate the date of the interruptions(s) or extension(s) and check whether the Interruption/extension was approved or unapproved:

	From Date:	**To Date:**
Personal/Family_____		
Academic remediation_____		
Health _____		
Financial _____		
Participation in joint degree Program (e.g., MD/PhD)		
Participation in non-research special study		
(e.g., fellowship, international experience)_____		
Participation in non-degree research _____		
Other:		
Other:		

Please Specify:

2. Do this individual's official records reflect that he/she was ever placed on academic or disciplinary probation during his/her medical education? **No**

If YES, please select the reason(s) for the probation, indicate the dates of placement on and removal from probation and attach additional documentation to this report:

	From Date:	**To Date:**
Academic Probation _____		
Probation for unprofessional conduct/behavioral _____		
Other:		

Please specify a reason:

3. Do this individual's official records reflect that he/she was ever disciplined for unprofessional conduct/behavioral reasons by the medical school or parent university? **No**

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

4. Do this individual's official records reflect that he/she was ever the subject of negative reports for behavioral reasons or an investigation by the medical school or parent university? **No**

If YES, please provide detailed documentation/information about the circumstances and outcome(s):

5. Do this individual's official records reflect that there were any limitations or special requirements imposed on the individual because of questions of academic incompetence, disciplinary problems, or any other reason? **No**

If YES, please provide detailed documentation/information about the nature of the limitations or special requirement:

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 **TEL**(817)868-5000 **FAX**(817)868-5099

Applicant Reported Unusual Circumstances

Medical School

Medical Professional Name: Aziza Alexia Wahby

Touro College of Osteopathic Medicine

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for: Aziza Alexia Wahby

PROVIDED BY APPLICANT

TOURO COLLEGE OF OSTEOPATHIC MEDICINE

KENNETH J. STEIER, DO, MPH, MHA
CLINICAL DEAN & PROFESSOR

230 West 125th Street
New York, NY 10027
Phone: (646) 981-4559
Fax: (212) 678-1785
kenneth.steier@touro.edu

Medical Student Performance Evaluation

For

Aziza Wahby

October 14, 2011

Identifying Information

Aziza Wahby is a fourth-year student at the Touro College of Osteopathic Medicine in Harlem, New York.

Unique Characteristics

Born to Dr. Samir and Mary Lou Wahby on April 9th, 1980 at the Brooklyn Hospital, Brooklyn, NY, Aziza Alexia Wahby is the grandchild of 3 physicians and the daughter of an orthopedic surgeon. A precocious child, she lovingly recited the anatomical differences between herself and her brother at the age of two, read completely by the age of four and began a music career at age seven after winning her first concerto competition. At 14, she traveled by invitation from her hometown of Fort Dodge, Iowa to Japan and the home of Dr. Sinichi Suzuki, founder of the Suzuki method of violin pedagogy. Graduating as salutatorian after only three years of high school, she entered the Cleveland Institute of Music and earned a master's degree in violin performance under the tutelage of William Preucil, Jr., concertmaster of the Cleveland Orchestra.

Although her music career led to performances at Carnegie Hall with the New York String Orchestra as well as the New World Symphony, performances in large

swaths of Europe and most of South America, she yearned for further education. In 2004, Aziza began a pre-med program at Columbia University, where she majored in psychology. She maintained a presence on the dean's list at Columbia University and eventually graduated with honors. Aziza entered Touro College of Osteopathic Medicine in 2008. Her strong work ethic and personal discipline will undoubtedly lead her to success.

Academic History

Date of Expected Graduation from Medical School:	June 26, 2012
Date of Initial Matriculation in Medical School:	August 11, 2008

Please explain any extensions, leaves of absence, gap(s) or breakdowns in the student's educational program: Not applicable

Was this student required to repeat or otherwise remediate any coursework during his/her medical education? No

Was the student the recipient of any adverse action(s) by the medical school or its parent institution? No

Academic Progress

Preclinical/Basic Science Curriculum

Aziza Wahby's academic performance has been consistently impressive. She established herself as a highly motivated student during her first year of basic sciences, receiving "A" grades in six of seven courses during the first and second semesters. Aziza excelled in her second and third years, earning A's or High Honors in the great majority of courses. At present, her career GPA stands at 3.9112 and she received a grade of 621/90 on the COMLEX-1. Her clinical preceptors' assessments of her abilities are noted in the paragraphs that follow.

Core Clinical Clerkships and Elective Rotations

Clerkship: OBGYN **Grade: A** **High Honors** **July 2010**

1) Attention to detail. 2) Showed breadth of clinical knowledge especially since this was her first rotation. 3) Excellent medical knowledge. 4) Energetic and dynamic with patients. 5) Enthusiastic.

Clerkship: Pediatric **Grade: A** **High Honors** **August 2010**

Aziza is a consistently high performing student. Her supervising attending described her as "reliable, mature, knowledgeable, motivated and caring". Aziza demonstrated great abilities in interacting with her pediatric patients in a caring professional manner.

Clerkship: Surgery **Grade: A** **High Honors** **October 2010**

Aziza Wahby is probably the finest medical student I have had the chance to work with in my career. She has a great aptitude for medicine, understanding Pathology of disease and its finer points including histologic/pathologic side of disease. Her mechanical skills are excellent; she learns fast and presentation of cases are the best I have ever seen in a student.

Clerkship: Internal Medicine **Grade: A** **High Honors** **December 2010**

Aziza is quick to learn and is self directed in adapting to new information. Just in these 2 weeks I have seen her gain confidence in her presentation style with a mature and comprehensive approach. She will be a strong choice for any residency at her choosing.

Clerkship: Family Medicine **Grade: A** **High Honors** **February 2011**

Student showed excellent leadership skill, great bedside manner, and great diagnosis. Student was eager and dynamic.

Elective,: Dermatology Research UCSF **Grade: A** **High Honors August 201**

thoughtful, precise, well prepared student--who will be an excellent physician isself motivated, well organized and a clear thinker

Summary

Touro College of Osteopathic Medicine - Medical Student Performance Evaluation for Aziza Wahby

As can be concluded from a review of Aziza's record, she is an outstanding student. During her tenure as a medical student, she has demonstrated a thorough understanding of the basic sciences and has harnessed this knowledge appropriately so as to excel in her clinical training. In addition to previous scores noted, Aziza completed the COMLEX 2 CE with a score of 799/99. This score is a testament to her superior abilities when compared to students at our school as well as those around the country.

While the Touro College of Osteopathic Medicine does not provide an official ranking of its students, it will make note of students in the top third of the class. Aziza easily falls into this category and is exceptionally high within the group. Any program will benefit from having this student. It will be the lucky program director under whom this student wishes to train.

Respectfully submitted,

Kenneth Steier, DO

Clinical Dean and Professor

Appendix A

Medical School Information Page

Touro College of Osteopathic Medicine
230 West 125th Street
New York, NY 10027
(646) 981-4500

The Touro College of Osteopathic Medicine opened in 2007. At that time we were the first new medical school to open up in the state of New York in 30 years. The mission of the medical school is:

> Touro College of Osteopathic Medicine is committed to preparing students to become outstanding osteopathic physicians who uphold the values, philosophy and practice of Osteopathic Medicine. Touro College of Osteopathic Medicine places special emphasis on teaching and learning in the areas of primary care, the holistic approach to the patient. Touro College of Osteopathic Medicine is committed to identify and recruit students who have specific interest in practicing in underserved communities, such as Harlem. The College advances the Osteopathic profession and serves the students and society by providing a firm educational foundation, encouragement of research and scholarly activity, and participation in community service.
>
> Touro College of Osteopathic Medicine functions as an integral part of the New York City/Harlem community, and work with the community, local schools, and other colleges and universities to promote the study of medicine, encourage continuing development, increase educational opportunities, and deliver Osteopathic medical services in a variety of community settings.
>
> Students learn the latest strategies for the management and treatment of patients in a broad range of social and economic settings. In addition to focusing on primary care, the School emphasizes the promotion of wellness from prenatal through geriatric care.

Program Description

The course of study is a four-year program that encompasses two years of classroom didactic study followed by two years of clinic clerkship experiences. The didactic program starts in the first year with a traditional medical school curriculum to include the basic sciences and introduction to clinical medicine classes. The second year is a modular program where clinical and basic science courses are integrated. Osteopathic principles and practice are incorporated into the curriculum in all four years. Core clinical clerkships include: internal medicine/medical subspecialty, family medicine/primary

care, pediatrics, obstetrics and gynecology, psychiatry, surgery/surgical subspecialty, critical care/anesthesiology, and emergency medicine. Geriatrics and radiology are covered throughout the inpatient and ambulatory experiences for the clerkships.

Eighty seven percent of our clinical clerkships are served in federally designated health service shortage areas.

Statistical assessments of student measurement instruments:
Touro College of Osteopathic Medicine utilizes statistical assessments to measure examinations and objective learning. Students are graded on a z-scale scoring systems graded against all students who have matriculated at the school. The Touro College of Osteopathic Medicine has not adopted class ranking at this stage in our development.

The faculty, staff, and administration of the Touro College of Osteopathic Medicine stands at the ready to recognize the students for their personal and collective attributes, dedication to the field of medicine, and their assumption of their role of future physicians during a time when the field of medicine is going through monumental changes. As Dean of the medical school, I am confident that the members of this trail-blazing class can handle the challenges presented to them with a level of professionalism, courtesy, and scholarship that is unparalleled.

- Touro College of Osteopathic Medicine requires COMLEX-USA Level I and II passage for graduation.
- All students are required to demonstrate satisfactory performance within the objective structured clinical evaluation (OSCE) as a requirement for promotion to serve clinical clerkships.
- The OSCE component of the education is encompassed in a standalone course as well as many other courses within the curriculum.
- The narrative comments contained in the MSPE are reported as written.
- Touro College of Osteopathic Medicine transcript for each student is in partial compliance with the AAMC guidelines.
- The students are permitted to review the MSPE prior to submission.

	2008-2009 Fall		
BSCI-600-E	BASIC SCIENCE FOUNDATION	6.00	A
BSCI-606-E	ANATOMY/EMBRYOLOGY	10.00	A
BSCI-608-E	INTRO TO BIOCHEM/TISSUES	1.00	A
OMM -610-E	OSTEOPATHIC MANIPULATIVE MEDICINE	3.00	B
PRCR-600-E	INTRO TO CLINICAL MEDICINE 1	1.00	A
PRCR-607-E	PHYSICAL DIAGNOSIS 1	2.00	A
PRCR-611-E	PREVENTIVE MEDICINE PUBLIC HEALTH	2.00	B
TERM ERN:	25.00 GPA CR: 25.00 QP: 95.00	GPA: 3.800	
CUM ERN:	25.00 GPA CR: 25.00 QP: 95.00	GPA: 3.800	
Dean's List			
	2008-2009 Spring		
BSCI-610-E	BASIC SCIENCE FOUNDATION II	9.00	A
BSCI-610-1	BIOCHEMISTRY	.00	
BSCI-610-2	HISTOLOGY	.00	
BSCI-610-3	PHYSIOLOGY	.00	
BSCI-617-E	BASIC SCIENCE INFECTION AND IMMUN	1.00	A
BSCI-619-E	NEUROSCIENCE	5.00	A
BSCI-620-E	PROBLEM BASED LEARNING	.50	A
OMM -621-E	OSTEOPATHIC MANIPULATIVE MEDICINE 2	3.00	A
PRCR-623-E	PHYSICAL DIAGNOSIS 2	2.00	B
TERM ERN:	20.50 GPA CR: 20.50 QP: 80.00	GPA: 3.902	
CUM ERN:	45.50 GPA CR: 45.50 QP: 175.00	GPA: 3.846	
Dean's List			
	2009-2010 Fall		
BSCI-624- -E	MEDICAL MICROBIOLOGY & IMMUNOLOGY 1	2.00	A
BSCI-633-E	PATHOLOGY I	5.00	A
BSCI-634-E	PHARMACOLOGY	4.00	A
OMM -625- -E	OSTEOPATHIC MANIPULATIVE MEDICINE 3	3.00	B
PRCR-626- -E	BEHAVIORAL MEDICINE & PSYCHIATRY I	1.00	A
PRCR-627- -E	CLINICAL SYSTEMS 1	7.00	A
PRCR-632- -E	PRIMARY CARE SKILLS 1	1.00	B
TERM ERN:	23.00 GPA CR: 23.00 QP: 88.00	GPA: 3.826	
CUM ERN:	68.50 GPA CR: 68.50 QP: 263.00	GPA: 3.839	

Continued

Dean's List

	2009-2010 Spring	
BSCI-636- -E	MEDICAL MICROBIOLOGY IMMUNOL	
BSCI-646- -E	PATHOLOGY 2	
BSCI-647- -E	PHARMACOLOGY 2	
CLIN-600- -E	INTRODUCTION TO ROTATIONS	
OMM -637-E	OSTEOPATHIC MANIPULATIVE MED	
PRCR-601-E	OSCE/EARLY CLINICAL EXPERIEN	
PRCR-638- -E	BEHAVIORAL MEDICINE PSYCHIAT	
PRCR-646- -E	CLINICAL SYSTEMS 2	
TERM ERN:	25.00 GPA CR: 24.00 QP: 94	
CUM ERN:	93.50 GPA CR: 92.50 QP: 357	
Dean's List		
	2010-2011 Summer	
CLIN-700-A-E	CORE ROTATION: INTERNAL MEDI	
CLIN-700-B-E	CORE ROTATION: INTERNAL MEDI	
CLIN-701-A-E	CORE ROTATION: GENERAL SURGE	
CLIN-701-B-E	CORE ROTATION: GENERAL SURGE	
CLIN-703- -E	CORE ROTATION: OB/GYN	
CLIN-704- -E	CORE ROTATION: PEDIATRICS	
TERM ERN:	36.00 GPA CR: 36.00 QP: 144	
CUM ERN:	129.50 GPA CR:128.50 QP: 501	
Dean's List		
	2010-2011 Spring	
CLIN-702-A-E	CORE ROTATION: FAMILY MEDICI	
CLIN-702-B-E	CORE ROTATION: FAMILY MEDICI	
CLIN-705- -E	CORE ROTATION: PSYCHIATRY	
CLIN-708- -E	SELECTIVE: EMERGENCY MEDICIN	
CLIN-716-A-E	ELECTIVE: 4 WK	
TERM ERN:	30.00 GPA CR: 30.00 QP: 120	
CUM ERN:	159.50 GPA CR:158.50 QP: 621	
Dean's List		

Continued next

TOURO COLLEGE

1570

SEAL VERIFIED

Federation Credentials Verificat
400 Fuller Wiser Road, Suite 300
Euless TX

AN OFFICIAL SIGNATURE IS WHITE WITH A GREEN BACKGROUND

REJECT DOCUMENT IF

This officially sealed and signed transcript is printed on green SCRIP-SAFE® security paper with the name of the college printed in white type across the face of the document. A raised seal is not required. When photocopied a security statement containing the institution name will appear. A BLACK ON WHITE OR A COLOR COPY SHOULD NOT BE ACCEPTED.

Lidia Meindl, U

THE NAME OF THE COLLEGE IS PRINTED ACROSS THE FACE OF THIS 11 X 8.5 INCH DOCUMENT · A BLACK AND WHITE DOCUME

Course	Description	Cred.	Grd.	Course	Description
	2011-2012 Fall				
CLIN-813-A-E	4 WK ELECTIVE DERMATOLOGY RSRCH	6.00	A		
CLIN-813-B-E	4 WK ELECTIVE DERMATOLOGY	6.00	A		
CLIN-813-C-E	4 WK ELECTIVE DERMATOLOGY	6.00	A		
CLIN-813-D-E	4 WK ELECTIVE DERMATOLOGY	6.00	A		
CLIN-854- -E	CLIN ROTATION: INTERNAL MEDICINE	6.00	A		
CLIN-862- -E	CLIN ROTATION: GENERAL SURGERY	6.00	A		
TERM ERN:	36.00 GPA CR: 36.00 QP: 144.00	GPA:	4.000		
CUM ERN:	195.50 GPA CR:194.50 QP: 765.00	GPA:	3.933		
Dean's List					
	2011-2012 Spring				
CLIN-809- -E	SURGICAL SUB SPECIALTY	6.00	A		
CLIN-813-E-E	4 WK ELECTIVE DERMATOLOGY	6.00	A		
CLIN-896- -E	MEDICAL SUB SPECIALTY	6.00	A		
CLIN-897- -E	CLIN ROT: CRITICAL CARE/ANESTHESIA	6.00	A		
CLIN-898- -E	PRIMARY CARE	6.00	A		
TERM ERN:	30.00 GPA CR: 30.00 QP: 120.00	GPA:	4.000		
CUM ERN:	225.50 GPA CR:224.50 QP: 885.00	GPA:	3.942		
Dean's List					

**** End of Record ****

Federation Credentials Verificat
400 Fuller Wiser Road, Suite 300
Euless TX

TOURO COLLEGE

AN OFFICIAL SIGNATURE IS WHITE WITH A GREEN BACKGROUND

REJECT DOCUMENT I

This officially sealed and signed transcript is printed on green SCRIP-SAFE® security paper with the name of the college printed in white type across the face of the document. A raised seal is not required. When photocopied a security statement containing the institution name will appear. A BLACK ON WHITE OR A COLOR COPY SHOULD NOT BE ACCEPTED.

Lidia Meindl, U

THE NAME OF THE COLLEGE IS PRINTED ACROSS THE FACE OF THIS 11 X 8.5 INCH DOCUMENT · A BLACK AND WHITE DOCUME

Touro College

Office of the Registrar
27 - 33 West 23rd Street
New York, NY 10010-4202

Ph. 212-463-0400
Fax 212-463-9259
transcripts@touro.edu

Accreditation

Touro College is accredited by the Middle States Commission on Higher Education as a degree granting institution on the undergraduate, graduate and professional levels.

Release of Information

In accordance with the Family Educational Rights and Privacy Act of 1974 this document cannot be released to a third party without the written consent of the student.

Academic Calendar

Touro College operates on a semester system. The calendar consists of two semesters during the academic year and optional summer sessions of varying lengths.

Historical Notes

During Fall 1971 only grades of **H** (Honors) and **P** (Passing) were given. From 1971 to Fall 1975 only passing grades were posted.
Prior to Fall 1981 grades of **WF** (Withdrawal: While Failing), **WU** (Withdrawal: Unofficial) and **WP** (Withdrawal: Passing) were posted.
Prior to Spring 2001 **NA** was assigned to students who never attended and did not withdraw from class (which was calculated as an **F)** and **CPR** (Credit on Permit Received) was assigned to students for transfer credits.
From Fall 1994 grade **G** (Failing) was changed to **WU** (Withdrawal: Unofficial).
U (Unsatisfactory) was assigned to students who fail to demonstrate sufficient effort, achievement and/or readiness to undertake future study.
R (Repeat Remedial Course) was assigned to students not yet ready to advance to the next level.
T (Passing Remedial Course) was assigned to students ready to proceed to the next remedial level.
YC (Year course) was assigned to students who were enrolled in year – long course.

Credits

A Credit Unit is normally 1 classroom contact hour of 50 minutes per week or an appropriate equivalent and requires 2 hours of preparation. A minimum of 120 credits are required for the Bachelor's Degree and a minimum of 60 for the Associate Degree. For graduate programs, consult the appropriate school catalog.

Dean's List

Full-time matriculated students from undergraduate schools who achieve records of excellence in any academic semester are placed on the "Dean's List." Criteria for the Dean's List are a course load of at least 12 credits a term and GPA of 3.40 or better in a given semester.

Undergraduate Graduation Honors

Summa Cum Laude	3.8 - 4.0
Magna Cum Laude	3.6 - 3.7
Cum Laude	3.4 - 3.5

Grading system

Grade	Grade Point Equivalent	Explanation
A+	4.0	Excellent
A	4.0	Excellent
A-	3.667	Excellent
B+	3.333	Good
B	3.0	Good
B-	2.667	Good
C+	2.333	Average
C	2.0	Average
C-	1.667	Average
D+	1.333	Poor but Passing
D	1.0	Poor but Passing
D-	0.667	Poor but Passing
F	0.0	Failure
P	0.0	Passing

Additional grades for Osteopathic Medicine program in NY

I	0.0	Incomplete
U	0.0	Unsatisfactory
U/C	2.0	Satisfactory with Remediation
WP	0.0	Withdrawal: Passing

Other grades

AUD	Audited Course
INC	Incomplete, Graduate Courses
IP	In Progress
N or NG	No Grade Submitted or Non-graded, Non-credit Course
T	Tentative, accompanied by a grade of no higher than a C-, which is calculated in GPA, Undergraduate Courses
W	Withdrawal
WF	Withdrawal: While Failing
WNA	Withdrawal: Never Attended
WU	Withdrawal: Unofficial

Touro College of Osteopathic Medicine

Be It Known That

Aziza Wahby

Having satisfied the requirements for the degree of

Doctor of Osteopathic Medicine

Has accordingly been admitted to that degree with all the rights, privileges and responsibilities thereunto appertaining

In testimony whereof the seal of the College and the signatures authorized by the Board of Trustees are hereunto affixed

Signed this twenty-sixth day of June Two Thousand Twelve

TOURO COLLEGE OF OSTEOPATHIC MEDICINE

Alan Kadish

Alan Kadish, M.D.
President, Touro College

Robert B. Goldberg, D.O.
Dean, Touro College of Osteopathic Medicine

Mark Hasten

Mark Hasten
Chairman, Board of Trustees

ELECTRONIC SEAL VERIFIED

Section V

Graduate Medical Education

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

Federation of STATE MEDICAL BOARDS

Federation Credentials Verification Service (FCVS)
400 Fuller Wiser Road, Suite 300, Euless, TX 76039
Tel: (817) 868-5000 Fax: (817) 868-5099

Verification of Graduate Medical Education

Institution: NSUCOM/Largo Medical Center
Attention: **TRADITIONAL ROTATING INTERNSHIP**
Specialty: Traditional
Affiliated University: _____
Address: Largo, FL

Verification For:
Name: Wahby, Aziza Alexia
DOB: 04/19/1980
Individual's Name on Record (If different from above):_____

Program Participation:
Important:
Report Incomplete Training Levels (years) separate from those that were successfully completed.

If the training level (year) is currently in progress report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department/Specialty is rotating or transitional, please provide a schedule of rotations.

Training Level: PGY 1 (e.g., 1, 2, 3, etc.)
☒ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: Traditional Rotating Internship
From: 07/01/2012 **To:** 06/30/2013
Successfully Completed?: ☒ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☒ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: _____
From: / / **To:** / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Training Level: _____ (e.g., 1, 2, 3, etc.)
☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship ☐ Research
Specialty/Subspecialty: _____
From: / / **To:** / /
Successfully Completed?: ☐ Yes ☐ No ☐ In Progress
Accredited by: ☐ ACGME ☐ AOA ☐ LCGME ☐ RSC ☐ CFPC ☐ RCPSC ☐ APPAP ☐ None of these

Unusual Circumstances:
Check the correct response. Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or break from his/her training? ☐ Yes ☒ No
2. Was this individual ever placed on probation? ☐ Yes ☒ No
3. Was this individual ever disciplined or placed under investigation? ☐ Yes ☒ No
4. Were any negative reports for behavioral reasons ever filed by instructors? ☐ Yes ☒ No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? ☐ Yes ☒ No

Please explain any "Yes" response from above:

_____

_____

Certification:

Affix your institutional seal in this space. If no seal is available, you must have this [illegible] clarified

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct. The signature line must contain the original signature, or the electronic typed signature, of the program director **(M.D./D.O. only)**.

Name: Anthony N. Ottaviani, DO, MPH
Signature: Anthony N. Ottaviani, DO, MPH
Title of Signatory: Director of Medical Education
Date of Signature: 7/6/2015
Tel: 727-588-5704 Fax: 727-585-7205 E-Mail: _____

ELECTRONIC SEAL VERIFIED

From: Susan.Tovar@hcahealthcare.com [mailto:Susan.Tovar@hcahealthcare.com]
Sent: Tuesday, July 07, 2015 1:05 PM
To: Latia Lovelace
Subject: RE: Rotation Schedule- Aziza Wahby FCVS ID: 341174

Please see below for the rotation schedule information.

INTERNS	7/1-7/29	7/30-8/26	8/27-9/23	9/24-10/21	10/22/11-11/18	11/19-12/16	12/17-1/13	01/14-02/10	02/11-03/10	03/11-04/7	04/08-05/5	05/6-06/2	06/3-06/30
Wahby	IM Amb-Garg	IM SEL-R/DERM	OUT ELECT	FP Amb-Markou	Hosp IM	SX SEL-Wound	FP SEL-FP-Howard	Hosp FP/Core	GEN SX-Fansler	ICU	Hosp FP/Core	Hosp IM	ER

Sue Tovar

Sue Tovar, C-TAGME
GME Manager – Sr. GME Coordinator
Largo Medical Center - Graduate Medical Education
201 14th Street SW - Largo, FL 33770
Phone: 727-588-5730 Fax: 727-585-7205
susan.tovar@hcahealthcare.com

Applicant Reported Unusual Circumstances

Graduate Medical Education

Medical Professional Name: Aziza Alexia Wahby

NSUCOM/Largo Medical Center

Traditional

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for: Aziza Alexia Wahby

PROVIDED BY APPLICANT

Largo Medical Center

West Coast Academic Center of Nova Southeastern University College of Osteopathic Medicine

Hereby Certifies That

Aziza A. Wahby, D.O.

has faithfully and successfully completed the

Traditional Rotating Internship Program

from

July 1, 2012 to June 30, 2013

Accredited by the American Osteopathic Association

Consortium for Excellence in Medical Education

Anthony Degina
Chief Executive Officer

Anthony N. Ottaviani, D.O., M.P.H.
Internship Program Director

Anthony N. Ottaviani, D.O., M.P.H.
Director of Medical Education and Chief Academic Officer

FCVS FEDERATION CREDENTIALS VERIFICATION SERVICE

Verification of Graduate Medical Education

Federation of STATE MEDICAL BOARDS

Institution: University Hospitals of Cleveland **Affiliated University:** University Hospitals of Cleveland

Address Line 1: 11100 Euclid Avenue

Address Line 2:

Country: US **City:** Cleveland **State/Prov.:** OH **Zip Code:** 44106

If name of institution was different when this individual attended, please note this name:

Verification For: Wahby, Aziza Alexia **Date of Birth:** April 19, 1980

Individual's Name on Record (If different from above): ,

Program Participation:

Important:

Report Incomplete Training Levels (year) separate from those that were successfully completed.

If the training level (years) is currently in progress, report the expected completion date in the "To" field.

Report Internships, Residencies and Fellowships separately.

Use one section per Department/Specialty. If the Department or Specialty is rotating or transitional, please provide a schedule of rotations.

Program Type	Training Level	From	To	Successfully Completed?	Specialty/Subspecialty	Accredited by
R	2-3	07/01/2013	06/30/2015	Yes	Dermatology	AOA
R	4	07/01/2015	06/30/2016	In Progress	Dermatology	AOA

If no, was credit awarded?

Unusual Circumstances

Check the correct response.

Omitted responses require written explanation.

If necessary, you may continue your explanation on a separate sheet of paper.

1. Did this individual ever take a leave of absence or extension from his/her training? No
   If "Yes" provide start and end dates: **From:** **To:**
2. Was this individual ever placed on probation? ..... No
3. Was this individual ever disciplined or placed under investigation? ..... No
4. Were any negative reports for behavioral reason ever filed by instructors? ..... No
5. Were any limitations or special requirements placed upon this individual because of questions of academic incompetence, disciplinary problems or any other reason? No

Please explain any "Yes" response from above:

Attestation

Affix Institutional Seal Here.

If no seal is available, this form must be notarized.

Watermark

For FCVS internal use only.

Completion attests the information above is an accurate account of this individual's records and is true and correct. Signature line must contain original signature or electronic typed signature of program director

Print Name: ArtthapolTanphaichitr **MD/DO:** Yes

Signature: *Artthapol Tanphaichitr*

Title: Program Director **Date:** 07/06/2015

Tel: (216) 844-5794 **Fax:** (216) 844-8993 **Email:** artthapol.tanphaichitr@UHhospitals.org

ELECTRONIC SEAL VERIFIED

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 TEL(817)868-5000 FAX(817)868-5099

Applicant Reported Unusual Circumstances

Graduate Medical Education

Medical Professional Name: Aziza Alexia Wahby
University Hospitals of Cleveland
Dermatology

Unusual Circumstances

Did you have any interruption(s) or extension(s) in your medical education?	Yes	**No**
Were you ever placed on probation?	Yes	**No**
Were you ever disciplined or placed under investigation?	Yes	**No**
Were any negative reports for behavioral reasons ever filed by instructors?	Yes	**No**
Were any limitations or special requirements imposed on you because of academic performance, incompetence, disciplinary problems or for any other reason?	Yes	**No**

End of report for: Aziza Alexia Wahby

PROVIDED BY APPLICANT

Section VI

Licensure Examination History

(State Licensing Authorities Only)

400 FULLER WISER ROAD | SUITE 300 | EULESS, TX 76039 | TEL(817)868-5000 | FAX(817)868-5099

COMPREHENSIVE OSTEOPATHIC MEDICAL LICENSING EXAMINATION - USA

Official Transcript

Federation Credentials Verification Svcs
Federation Place
400 Fuller Wiser Rd., Ste. 300
Euless, TX 76039-3855

Examinee: Wahby, Aziza
NBOME ID: 974848 **Date of Birth:** 04/09/1980

EXAMINATION	DATE COMPLETED	PASS / FAIL	3 - DIGIT STANDARD SCORE	3 - DIGIT MINIMUM PASSING	2 - DIGIT STANDARD SCORE	2 - DIGIT MINIMUM PASSING	NOTE
Level 1							
	22-Jun-2010	Pass	621	400	--		
Level 2 Cognitive Evaluation (CE)							
	30-Jun-2011	Pass	799	400	--		
Level 2 Performance Evaluation (PE)							
	01-Jun-2011	Pass	Not Applicable		Not Applicable		
Level 3							
	29-Apr-2013	Pass	867	350	--		

The National Board of Osteopathic Medical Examiners, Inc., does hereby certify the above to be a true report of the examinee.

Date Prepared: July 09, 2015

1113718310810461

-- please see reverse for information and description of notes -- v3.0

National Board of Osteopathic Medical Examiners, Inc.
8765 West Higgins Road Suite 200 Chicago IL 60631-4174
Phone: 773/714-0622 Fax: 773/714-0631

341174

State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

Verification of Licensure

This letter is to verify that the records of the State Medical Board of Ohio contain the following information for the indicated licensee as of 6/19/2020. Please note that this status could change if there is future disciplinary action.

Full Name:	Aziza Wahby
Date of Birth:	04/09/1980
Type of License:	Doctor of Osteopathic Medicine (DO)
License Number:	34.011998CTR
Original Licensure Date:	10/14/2015
Effective Date:	8/27/2019
Expiration Date:	10/01/2021
Status:	Active
Sub-status:	
Board Action:	No
Board Action Summary:	

STATE MEDICAL BOARD OHIO

Please visit elicense.ohio.gov/oh_verifylicense to view Board actions available to the public. If you need additional information or to receive certified copies of a public record, please send an email request to Med-PublicRecordRequests@med.ohio.gov. All communications to the Board must include the name and license number of the licensee. For general license verification questions, send an email to license@med.ohio.gov.

14 3844

State Medical Board of Ohio

med.ohio.gov 30 E. Broad St., 3rd Floor · Columbus, OH 43215-6127 · (614) 466-3934

Ohio Physician Licensure Application

1. ***Indicate License Type*** ○ M.D. ● D.O. ○ M.D. Telemedicine ○ D.O. Telemedicine

2. ***Name: Indicate your full legal name. Please list any maiden names or other names used.***

Last	First	Middle	Suffix
~~Aziza~~ Wahby	Aziza	Alexia	

Maiden Name

All other names used

3. ***Contact Information:*** *Please complete all sections*

Indicate which address you wish to use for mailings from the Medical Board. ○ Practice Address ● Home Address

Practice Address

Street 1 | Phone Number

Street 2 | Fax Number

City | State | Zip Code | email

Home Address

Street 1: 2303 Bellfield Ave | Phone Number: 515 574 9238

Street 2: apt 1 | Fax Number

City: Cleveland Heights | State: OH | Zip Code: 44106 | email: azizawahby@gmail.com

4. ***Identification***

Date of birth	Birth City	State	Country
4/9/80	New York	NY	USA

SSN: Redacted

Gender: ○ Male ● Female

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.). It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760., 4762., or 4778. O.R.C. or as otherwise required by state or federal law.

MEDICAL BOARD

AUG 28 2015

Wahby

PE # 132275

5. Preliminary Education.

High School or equivalent: St. Edmond High School

City: Fort Dodge | State: IA | Country: USA

Date From: 1994 | Date To: 1997

Undergraduate College 1: Cleveland Institute of Music

City: Cleveland | State: OH | Country: USA

Date From: 1997 | Date To: 2001 | Degree: Bachelor of Music

Undergraduate College 2: Columbia University

City: New York | State: NY | Country: USA

Date From: 2004 | Date To: 2008 | Degree: BA

6. TOEFL- IBT. This section is only required to be completed by International Medical School Graduates.

The TOEFL, TWE, ECFMG's ENGLISH EXAM (PRIOR TO 7/1/98), ETC., ARE NOT EQUIVALENT AND CANNOT BE SUBSTITUTED FOR THE TOEFL-IBT.

Graduates of medical schools located outside the United States and Canada must achieve a score of at least 26 in Speaking and 26 in Listening with a total score of 90 on the TOEFL-IBT, regardless of citizenship or country of birth. Prior to July 2006 the Test of Spoken English was required with a minimum score of 40 (between 7/95 and 7/06) or 230 (prior to 7/95). The following are the only exceptions permitted under Ohio law:

○ YES ○ NO Have you completed two years of undergraduate college work in the United States?

○ YES ○ NO During the five years immediately preceding the date of your application have you:

Held a current medical license (i.e., unrestricted, training certificate, educational permit) in the United States **AND** Have you been actively practicing medicine (graduate medical education is included) in the United States?

○ YES ○ NO Have you completed a Fifth Pathway program?

○ YES ○ NO Have you passed the Clinical Skills Assessment exam given by the ECFMG on or after July 1, 1998?

If you answered 'NO' to all of the above, you are required to take the TOEFL-IBT. Please refer to the instructions for information on contacting the Educational Testing Service. The Board cannot waive this requirement.

7. Ohio Training Program.

○ YES ○ NO Are you or will you be in an accredited training program in Ohio? If yes, please identify the program below.

Program Name: University Hospitals of CLE, Dermatology

8. Military.

○ YES ○ NO Are you currently in the United States Military or Reserves or a Military Veteran?

○ YES ○ NO Are you the spouse of an individual currently serving in the United States Military or Reserves?

9. Medical School: *List all medical schools you have attended, including those from which you did not graduate in chronological order. Attach and additional sheet if necessary.*

1. School Name: Touro College of Osteopathic Medicine
Address:
City: New York State: NY Zip Code: 10025
Country:
Date From:
Date To:
Graduation Date: 6/2012
Degree: DO

2. School Name:
Address:
City: State: Zip Code:
Country:
Date From:
Date To:
Graduation Date:
Degree:

10. Postgraduate Training: *List all postgraduate programs you have attended, including those you did not complete. Copy and attach additional pages if necessary.*

1. Hospital Name: Largo Medical Center
Address: 201 14th st SW
City: Largo State: FL Zip Code: 33770
Country: USA
Department/Specialty: Traditional Rotating Internship
Date From: 7/12 - 6/30
Date To: 6/13
Successfully Completed? (Yes) ( ) No
PGY (1) ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) other
PGT (Internship) ( ) Residency ( ) Fellowship ( ) Research ( ) other

2. Hospital Name: UH Richmond Hts Medical Ctr
Address: 27 100 Chardon Rd
City: Richmond Hts State: OH Zip Code: 44143
Country: USA
Department/Specialty: dermatology
Date From: 7/13
Date To: 6/16
Successfully Completed? ( ) Yes ( ) No
PGY ( ) 1 (2) (3) (4) ( ) 5 ( ) other
PGT ( ) Internship (Residency) ( ) Fellowship ( ) Research ( ) other

3. Hospital Name:
Address:
City: State: Zip Code:
Country:
Department/Specialty:
Date From:
Date To:
Successfully Completed? ( ) Yes ( ) No
PGY ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) other
PGT ( ) Internship ( ) Residency ( ) Fellowship ( ) Research ( ) other

4. Hospital Name | Date From
Address | Date To
City | State | Zip Code
Country | Successfully Completed? ○ Yes ○ No
Department/Specialty:

PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other

PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

5. Hospital Name | Date From
Address | Date To
City | State | Zip Code
Country | Successfully Completed? ○ Yes ○ No
Department/Specialty:

PGY ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ other

PGT ○ Internship ○ Residency ○ Fellowship ○ Research ○ other

11. Examination History: *List each licensure examination you have taken (USMLE, NBME, NBOME, LMCC, Etc.). If additional space is necessary, copy and attach an additional sheet.*

Examination	Date Taken (mm,yyyy)	Pass / Fail	No. of Attempts
USMLE Step 1		○ Pass ○ Fail	
USMLE Step 2 CK		○ Pass ○ Fail	
USMLE Step 2 CS		○ Pass ○ Fail	
USMLE Step 3		○ Pass ○ Fail	
COMLEX Level 1	6/22/2010	✓ Pass ○ Fail	1
COMLEX Level 2 CE	6/30/2011	✓ Pass ○ Fail	1
COMLEX Level 2 PE	6/1/2011	✓ Pass ○ Fail	1
COMLEX Level 3	4/29/2013	✓ Pass ○ Fail	1
NBME Part I		○ Pass ○ Fail	
NBME Part II		○ Pass ○ Fail	
NBME Part III		○ Pass ○ Fail	
NBOME Part I		○ Pass ○ Fail	
NBOME Part II		○ Pass ○ Fail	
NBOME Part III		○ Pass ○ Fail	
LMCC Part I		○ Pass ○ Fail	
LMCC Part II		○ Pass ○ Fail	
FLEX Componet 1		○ Pass ○ Fail	
FLEX Componet 2		○ Pass ○ Fail	
FLEX Pre-1985		○ Pass ○ Fail	

State Board Exam	Date Taken	State taken for	No. of Attempts	Pass / Fail
				○ Pass ○ Fail

12. *ECFMG and Fifth Pathway*

Certificate Number | Issue Date

School Name | Date From
Address | Date To
City | State | Zip Code | Graduation Date
Country | Degree

13. *State or Professional Licensure:* *List all state and Canadian provinces where you currently hold or have ever held any type of medical/osteopathic license. You must complete the attached "Licensure Verification" form (Form #1) and forward it to all states in which you have held any healthcare license or certification. The verifying entity must forward all documentation directly to the Board. Some state boards charge a fee for this information. Contact the state board where you hold or held a license to determine their requirements. (Attach additional pages if necessary).*

	State / Province	License Type	License Number	License Status		Issue Date
1	FL	training	U 03185	○ Active	● Inactive	5/15/2012
2	OH	training	58.005302	● Active	○ Inactive	11/6/2013
3				○ Active	○ Inactive	
4				○ Active	○ Inactive	
5				○ Active	○ Inactive	
6				○ Active	○ Inactive	
7				○ Active	○ Inactive	
8				○ Active	○ Inactive	
9				○ Active	○ Inactive	
10				○ Active	○ Inactive	
11				○ Active	○ Inactive	
12				○ Active	○ Inactive	
13				○ Active	○ Inactive	
14				○ Active	○ Inactive	
15				○ Active	○ Inactive	

14. *Specialty Board Certification:* *Are you ABMS and / or AOA certified?* ○ Yes ● No

*If **Yes** complete information below*

Name of Board | Certificate Number | Issue Date
Name of Board | Certificate Number | Issue Date
Name of Board | Certificate Number | Issue Date

15. Chronology of Activities: *List ALL activities (medical, non-medical, and postgraduate training) in chronological order beginning with medical school graduation to the PRESENT date, using **MONTH** and **YEAR**. For any non-working time, you MUST state on the form exactly what your activities were, such as "vacation" or "seeking employment," as well as your permanent address. If you worked for a physician-staffing group or did locum tenens, you must list all facilities where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME FOR THIS FORM**. Be sure to indicate the percentage of working time spent in clinical /administrative duties.*

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 7 Year: 2012

TO: Month: 6 Year: 2013 ○ In Progress

Activity/Employer Name *(Non-Working*)*: Traditional Rotating Internship

Activity Address: 201 14th St SW

City: Largo State: FL Zip Code: 33770

Position / Department: Intern / GME

Percent Clinical: 100% Percent Administrative: 0%

✓ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Internship

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: 7 Year: 2013

TO: Month: Year: ✓ In Progress

Activity/Employer Name *(Non-Working*)*: University Hospitals Richmond

Activity Address: 27100 Chardon Rd

City: Richmond Hts State: OH Zip Code: 44143

Position / Department: Dermatology Resident / GME

Percent Clinical: 100% Percent Administrative: 0%

✓ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Dermatology Resident

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: Month: Year:

TO: Month: Year: ○ In Progress

Activity/Employer Name *(Non-Working*)*:

Activity Address:

City: State: Zip Code:

Position / Department:

Percent Clinical: Percent Administrative:

○ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: *Month* / *Year*

TO: *Month* / *Year* / ○ In Progress

Activity/Employer Name *(Non-Working*)*

Activity Address

City | State | Zip Code

Position / Department

Percent Clinical | Percent Administrative

○ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

Dates: From/To | Activity *(medical, non-medical and post graduate training)*

FROM: *Month* / *Year*

TO: *Month* / *Year* / ○ In Progress

Activity /Employer Name *(Non-Working*)*

Activity Address

City | State | Zip Code

Position / Department

Percent Clinical | Percent Administrative

○ Employment ○ Staff Privileges ○ Administrative ○ Other, Please describe below

16. Malpractice: *List of all claims or suits for medical malpractice made against you. A claim is any formal or informal demand for payment to any person or organization. If you do not have any such claims or suits, this section will be blank. Please provide a detailed written description of the background and medical issues involved in each case. Attach additional sheets if necessary.*

Name of patient involved: | State action took place

Name of Court | Case Number (if applicable:

Current status of claim: ○ Open (pending) ○ Closed (settled or judgment) ○ Dismissed (no money paid out)

Amount of judgment or settlement: | Amount paid on your behalf

Month and Year of incident | Month and Year of lawsuit

Insurance carrier at the time

What is / was your status: ○ Primary Defendant ○ Co-defendant ○ Other

Name of patient involved: | State action took place

Name of Court | Case Number (if applicable:

Current status of claim: ○ Open (pending) ○ Closed (settled or judgment) ○ Dismissed (no money paid out)

Amount of judgment or settlement: | Amount paid on your behalf

Month and Year of incident | Month and Year of lawsuit

Insurance carrier at the time

What is / was your status: ○ Primary Defendant ○ Co-defendant ○ Other

Ohio Addendum to Application
ADDITIONAL INFORMATION QUESTIONS

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a separate sheet of paper. You must submit copies of all relevant documentation, such as court pleadings, court or agency orders, and institutional correspondence and orders. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

○ Yes ● No 1. Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?

○ Yes ● No 2. Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?

○ Yes ● No 3. Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?

○ Yes ● No 4. Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?

○ Yes ● No 5. Have you ever transferred from one graduate medical education program to another?

○ Yes ● No 6. Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?

○ Yes ● No 7. Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?

○ Yes ● No 8. Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?

○ Yes ● No 9. Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?

○ Yes ● No 10. Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?

○ Yes	● No	11. Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?
○ Yes	● No	12. Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?
○ Yes	● No	13. Have you ever been notified of any charges, allegations, or complaints filed against you with any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?
○ Yes	● No	14. Have you ever been denied or have you ever surrendered a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?
○ Yes	● No	15. Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.
○ Yes	● No	16. Have you ever been arrested, forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? If yes, submit copies of all relevant documentation, such as police reports, certified court records and any institutional correspondence and orders. Photocopies will not be accepted.
○ Yes	● No	17. Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.
○ Yes	● No	18. Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?
○ Yes	● No	19. Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?
○ Yes	● No	20. Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?
○ Yes	● No	21. Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism?

○ Yes ○ No 22. a) Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?

○ Yes ○ No 22. b) Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?

If you answered YES" to any part of this question, please provide details on a separate sheet, including date of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

***"Ability to practice medicine"** is to be construed to include all of the following:*

1. *The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and*
2. *The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and*
3. *The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.*

***"Medical condition"** includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.*

○ Yes ○ No 23. Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? **You may answer "NO" to this question if** you hold a current training certificate to pursue training in Ohio and the only such medical condition is chemical dependency or substance abuse, and you have successfully completed or are currently receiving treatment at a program approved by this board and have adhered to all statutory requirements as contained in Sections 4731.224 and 4731.25, O.R.C., and related provisions. Any questions concerning approval can be directed to the board offices.

○ Yes ○ No a) Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment or received treatment in the past (with or without medication) or participate in a monitoring program?

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

○ Yes ○ No b) Are the limitation or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

○ Yes ○ No 24. Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety?

○ Yes ○ No a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

○ Yes ● No b) Are the limitation or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?

For purposes of question 25 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

○ Yes ● No 25. Are you currently engaged in the illegal use of controlled substances?

○ Yes ● No a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances.

This form must be completed if you have responded yes to Additional Information Question #I5 and/or #16.
Make additional copies of this form as needed.

Name of applicant _____ Date of incident _____

Location of Incident (City / State) _____

Were you arrested:
○ Yes ○ No

If the incident was alcohol-related, did you submit to a breath, blood, urine or other test to determine the amount of alcohol in your body?

If Yes, type if test and result _____

What offense(s) were you charged with? _____

Were the charges amended?:
○ Yes ○ No

If Yes, what were the final charges _____

Disposition:
○ Pending ○ Charges Dismissed ○ Charges Dropped ○ Conviction
○ Plea _____
○ Other _____

You must provide a detailed written explanation of the event including a description of the event, what led up to the event and what was learned. This must be described in your own words. Do not reference attached documentation. If additional space is needed, attach a separate sheet. Submit copies of the police report/arrest record, a copy of the charges or ticket, a copy of the final court disposition and any other relevant documentation.

To Mail you application:

You cannot save data typed into this form. Please print 2 copies of your completed form. Keep one copy for your records and mail the other copy to:

State Medical Board of Ohio
30 E. Broad Street, 3rd Floor
Columbus, Ohio 43215

State Medical Board of Ohio

med.ohio.gov 30 E. Broad St., 3rd Floor · Columbus, OH 43215-6127 · (614) 466-3934

Affidavit and Authorization for Release of Information: You must attach a recent (less than 6 months old) passport quality, color photograph of yourself to this form. Take the form to a notary public and sign the form in the presence of the notary public. The notarized form then must be sent directly to this Board.

Affidavit and Authorization For Release of Information

I, the undersigned, being duly sworn, hereby certify under oath that I am the person named in this application, that all statements I have or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished with respect to my application and that all documents, forms or copies thereof furnished or to be furnished with respect to my application are strictly true in every aspect.

I acknowledge that I have read and understand the Application for Physician Licensure and have answered all questions contained in the application truthfully and completely. I further acknowledge that failure on my part to answer questions truthfully and completely may lead to my being prosecuted under appropriate federal and state laws.

I authorize and request every person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me to furnish to the Board any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Board or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application.

I hereby release, discharge and exonerate the Board, its agents or representatives and any person, hospital, clinic, government agency (local, state, federal or foreign), court, association, institution or law enforcement agency having custody or control of any documents, records and other information pertaining to me of any and all liability of every nature and kind arising out of investigation made by the Board.

I will immediately notify the board in writing of any changes to the answers to any of the questions contained in this application if such a change occurs at any time prior to a license to practice medicine being granted to me by the board

I understand my failure to answer questions contained in this application truthfully and completely may lead to denial, revocation, or other disciplinary sanction of my licensure or permit to practice medicine.

Applicant's Signature (must be signed in the presence of a notary

Wahby
Applicant's Printed Last Name

Aziza
Applicant's Printed First Name, Middle Initial and Suffix (e.g., Jr.)

8/24/15
Date of Signature

Kristina J. Myers
Notary Public Signature

2/25/2016
Date Commission Expires

Subscribed and Sworn to before me on this 24th day of August ,20 15

Kristina J. Myers
Notary Public in
and for the State of Ohio
My commission expires Feb. 25, 2016

MEDICAL BOARD
AUG 28 2015

August 25, 2015

Ohio, State Medical Board of
77 S High St, 17th Fl
Columbus, OH 43215

RE: License Certification for Aziza Alexia Wahby

To Whom It May Concern:

This is to certify the following informtion, maintained in the records of the Department of Health, for the above referenced Health Care Practitioner:

PROFESSION:	Osteopathic Physician
LICENSE NUMBER:	UO3185
ORIGINAL CERTIFICATION:	05/15/2012
EXPIRATION DATE:	06/30/2013
CURRENT STATUS OF LICENSE:	NULL AND VOID
AGENCY ACTION:	None

This license information was last updated on: 08/25/2015

To expedite the verification process, the above format is the standard format for all healthcare practitioners. If you have questions regarding the status of this license, please call the Customer Contact Center at (850) 488-0595.

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

10/14/2015

Dr. Aziza Alexia Wahby

This is to notify you that you are now licensed to practice medicine or osteopathic medicine and surgery in the State of Ohio. The Board approved your request and your license number **011998** was issued on **10/14/2015** and will expire on **10/01/2017**.

Enclosed is your wallet card and wall certificate. The wall certificate, by law, must be displayed in your office or the place where a major portion of your practice is conducted.

Please be advised that verification of your Ohio license must be obtained directly from the Board's website at http://med.ohio.gov in the "Licensee Profile and Status section. The website is updated immediately to reflect newly issued licenses.

The Ohio Medical Board operates a "staggered renewal" system based upon the first letter of your last name at the time of licensure. Enclosed is a chart and information outlining the staggered medical license renewal system and continuing medical education (CME) hours required. Renewal applications are mailed approximately six months prior to the date of expiration. CME information may also be obtained from the Board's website.

SECTION 4731.281, OHIO REVISED CODE REQUIRES WRITTEN NOTICE TO THE BOARD OF ANY CHANGE OF PRINCIPAL PRACTICE ADDRESS OR RESIDENCE ADDRESS WITHIN THIRTY DAYS OF THE CHANGE. *A CHANGE OF ADDRESS FORM IS AVAILABLE ON THE BOARD'S WEBSITE.*

This notice authorizes you to make application for a U.S. Drug Enforcement Administration certificate of registration (controlled substance permit). To make such application, contact:

Drug Enforcement Administration (DEA)
431 Howard St.
Detroit, Michigan 48226
(800) 230-6844
www.deadiversion.usdoj.gov/

Any questions regarding the DEA registration must be directed to the DEA office.

Sincerely,

Mitchell Alderson
Chief, Licensure

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

APPLICATION FOR TRAINING CERTIFICATE

PLEASE TYPE OR PRINT CLEARLY

NOTE: Application fee is $75.00. Fees submitted are neither refundable nor transferable.

PERSONAL INFORMATION

Check only one: ☐ MD ☒ DO

Your social security number is required to facilitate reporting to the federal Healthcare Integrity & Protection Data Bank (42 U.S.C. §1320a-7e(b), 5 U.S.C. §552a, and 45 C.F.R. pt. 61) and for accurate identification under the federal and state child support enforcement law (42 U.S.C. §666 and §3123.50, O.R.C.) It may also be used for reporting to the National Practitioner Data Bank (42 U.S.C. §11101 and 45 C.F.R. pt. 60) and for other investigative/enforcement purposes in compliance with Chapters 4730., 4731., 4760. or 4762., O.R.C. or as otherwise required by state or federal law.

U.S. Social Security Number: Redacted

Full Name (Use no initials):	Last (Surname)	First	Middle	Suffix (Jr., II)
	Wahby	Aziza	Alexia	

Maiden Name Or Other Names Used (If none, enter "NONE"):	Last (Surname)	First	Middle	Suffix (Jr., II)

Physicians Address (Be sure to notify the Board of any change in address):	Number & Street			
	1701 E 12th St apt 11i			
	City	State	Zip Code	Country
	Cleveland	OH	44114	

TRAINING PROGRAM INFORMATION

Ohio Training Program Address (Hospital in Ohio where you will be starting your training):	Hospital & Department		
	University Hospitals / Case Medical Ctr		
	Number & Street		
	11100 Euclid Ave		
	City	State	Zip Code
	Cleveland	OH	44106

Dates of Training: Beginning Date: Mo/Day/Yr 7/1/13 Ending Date: Mo/Day/Yr 7/1/16

J-1 and H-1B VISA

To be completed by International medical school graduates only:

Are you currently applying for a J-1 or an H-1B Visa? ☐ YES ☐ NO

If YES check which one? ☐ J-1 ☐ H-1B

MEDICAL BOARD
JUN 27 2013

MEDICAL OR OSTEOPATHIC EDUCATION

Medical or Osteopathic School of Graduation:

School Name: Touro College of Osteopathic Medicine
City: New York | State: NY | Country: USA

Dates Attended: From: Mo/Yr 9 / 08 To: Mo/Yr 6 / 12

Degree Received: Doctor of Osteopathic Med Date Received: Mo/Day/Yr 6 / 5 / 12

Other Medical or Osteopathic Schools Attended **(If none, enter "NONE")**

School Name: NONE
City | State | Country

Dates Attended: From: Mo/Yr / To: Mo/Yr /

Reason degree not received at this school:

FIFTH PATHWAY PROGRAM

Fifth Pathway Program **(if none, enter "NONE")**:

Hospital or Institution: NONE
Name of Medical School
City | State | Country

Dates Attended: From: Mo/Yr / To: Mo/Yr /

ECFMG CERTIFICATE

To be completed by International medical school graduates only:

Do you have a valid ECFMG certificate? ☐ YES ☐ NO

Number:_____ Date Issued: Mo/Day/Yr / / Expires: Mo/Day/Yr / /

Applicant Name: Aziza Alexia Wahby Date: 6/16/13

MEDICAL BOARD
JUN 27 2013

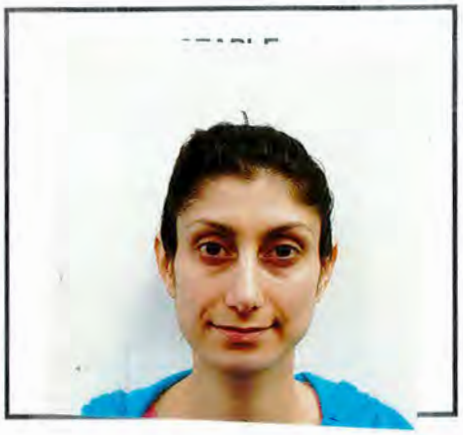
PHYSICAL DESCRIPTION

Staple a recent (taken within the last six months) passport-type **COLOR** photograph of applicant in the space provided below. Black and white photographs cannot be accepted.

Birth Date: Mo/Day/Yr 4/9/80

Birth Place: City New York | State NY | Country USA

Gender: ☐ Male ☒ Female For statistics only (optional)



PHYSICAL DESCRIPTION

Height 5'6"

Weight 105

Hair Color brown

Eye Color brown

Identifying Marks _____

Date Photo Taken: 6/13 mo/yr

LICENSES IN THE UNITED STATES & CANADA

List ALL states/provinces, whether the license is current or not, in which you are or have been licensed, including temporary, educational permits, limited licenses, etc., to practice medicine and surgery or osteopathic medicine and surgery. Indicate license number, date of issuance and the type of license. If additional space is needed, attach an extra sheet. **(If none, enter "NONE") A Form 2, Verification of License form must be sent to each state listed.**

STATE/PROVINCE	ISSUE DATE	LICENSE #	TYPE OF LICENSE	LICENSE CURRENT
	MO/YR		*✓ ONLY ONE*	*✓ ONLY ONE*
FL	6/12		☐ Full, unrestricted ☒ Temporary ☐ Educational ☒ Limited ☐ Other:_____ *(please specify)*	☒ YES ☐ NO Expiration Date: 7/13
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date:
			☐ Full, unrestricted ☐ Temporary ☐ Educational ☐ Limited ☐ Other:_____ *(please specify)*	☐ YES ☐ NO Expiration Date:

Applicant Name: Aziza Alexia Wahby Date: 6/16/13

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
RESUME OF ACTIVITIES

List ALL activities in chronological order from the date of medical school graduation to the PRESENT time, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the resume exactly what your activities were, such as "vacation" or "seeking employment", and indicate your permanent home address for that time period.* If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did "locum tenens", you must list all hospitals where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME OR CV FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, please attach separate sheets.

❑ **Check here if you are a new graduate (within 3 months). You DO NOT need to complete this form.**

From / Month/Year To / Month/Year	Hospital/University name, Other or non-working activity Complete Number & Street Address City / State/Country / Zip Code	Position & Department	%Clinical / %Admin.
From / Month/Year To / Month/Year	Largo Medical Center 201 W 14th St Largo FL 33770	GME intern	100
From / Month/Year To / Month/Year			
From / Month/Year To / Month/Year			
From / Month/Year To / Month/Year			
From / Month/Year To / Month/Year			

Applicant Name: Date:

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
ADDITIONAL INFORMATION

If you answer "YES" to any of the following questions, you are required to furnish complete details, including date, place, reason and disposition of the matter. All affirmative answers must be thoroughly explained on a ***separate sheet of paper (DO NOT write explanations on these pages)***. Please note that some questions require very specific and detailed information. Make sure all responses are complete.

(Please place a ☑ in the yes or no box)

		YES	NO
1.	Have you ever been denied staff membership at any hospital, nursing home, clinic, health maintenance organization, or similar institution?	☐	☑
2.	Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited, had privileges suspended or terminated, been put on probation, or been requested to withdraw from or resign privileges at any hospital, nursing home, clinic, health maintenance organization, or other similar institution in which you have trained, been a staff member, or held privileges, for reasons other than failure to maintain records on a timely basis, or failure to attend staff or section meetings?	☐	☑
3.	Have you ever resigned from, withdrawn from, or terminated, or have you ever been requested to resign from, withdraw from, or otherwise been terminated from, a position with a medical partnership, professional association, corporation, health maintenance organization, or other medical practice organization, either private or public?	☐	☑
4.	Have you ever resigned from, withdrawn from, or have you ever been warned by, censured by, disciplined by, been put on probation by, been requested to withdraw from, dismissed from, been refused renewal of a contract by, or expelled from, a medical school, clinical clerkship, externship, preceptorship, residency, or graduate medical education program?	☐	☑
5.	Have you ever transferred from one graduate medical education program to another?	☐	☑
6.	Have you ever, for any reason, lost specialty board certification in the U.S. or elsewhere, or been denied such certification, or denied examination for such certification?	☐	☑
7.	Has any board, bureau, department, agency or other body, including those in Ohio, in any way limited, restricted, suspended, or revoked any professional license, certificate or registration granted to you; placed you on probation; or imposed a fine, censure or reprimand against you?	☐	☑
8.	Have you ever voluntarily surrendered, resigned, or otherwise forfeited any professional license, certificate or registration issued to you by any board, bureau, department, agency, or other body; or have you ever withdrawn any application for licensure, relicensure, or examination, in any state (including Ohio), territory, province, or country?	☐	☑
9.	Have you ever, for any reason, been denied licensure or relicensure, application for licensure or relicensure, or the privilege of taking an examination, in any state (including Ohio), territory, province, or country?	☐	☑

Applicant Name: Aziza Alexia Wahby Date: 6/16/13

MEDICAL BOARD

JUN 27 2013

		YES	NO
10.	Have you ever been requested to appear before any board, bureau, department, agency, or other body, including those in Ohio, concerning allegations against you?	☐	☑
11.	Have you ever entered into an agreement of any kind, whether oral or written, with respect to a professional license, in lieu of or in order to avoid formal disciplinary action, with any board, bureau, department, agency, or other body, including those in Ohio?	☐	☑
12.	Have you ever been notified of any investigation concerning you by any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
13.	Have you ever been notified of any charges, allegations, or complaints filed against you with, any board, bureau, department, agency, or other body, including those in Ohio, with respect to a professional license?	☐	☑
14.	Have you ever been denied, or have you ever surrendered, a state or federal controlled substance or drug registration; had it revoked, terminated, or restricted in any way; or been warned, reprimanded, or fined by, or been requested to appear before, the responsible agency?	☐	☑
15.	Have you ever pled guilty to, been found guilty of a violation of any law, or been granted intervention or treatment in lieu of conviction regardless of the legal jurisdiction in which the act was committed, other than a minor traffic violation? If yes, submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. ***Photocopies will not be accepted***.	☐	☑
16	Have you ever been arrested or forfeited collateral, bail, or bond for breach or violation of any law, police regulation, or ordinance other than for a minor traffic violation; been summoned into court as a defendant or had any lawsuit filed against you (other than a malpractice suit)? Please be advised that you are required to submit copies of all relevant documentation, such as police reports, ***certified*** court records and any institutional correspondence and orders. ***Photocopies will not be accepted***. If case has been expunged you must submit certified letter from court.	☐	☑
17.	Have you been a defendant in a legal action involving professional liability (malpractice), or had a professional liability claim paid on your behalf, or paid such a claim yourself? If yes, you must complete the enclosed malpractice claim information form. In addition, ask your malpractice insurance carrier(s) to provide a complete claims history report for the last 10 years to the State Medical Board of Ohio. If your current carrier has provided coverage for less than 10 years, ask your previous carrier to submit a claims history report to the Board.	☐	☑
18.	Have you ever been denied professional liability insurance or coverage, or had such insurance or coverage canceled, limited, or restricted in any way?	☐	☑
19.	Have you ever been denied or relinquished participation in any third party reimbursement program, whether governmental or private, including Medicaid and Medicare; or had such participation limited, restricted, suspended, or revoked; or been warned, reprimanded, requested to appear before, or fined by the responsible body?	☐	☑
20.	Have you ever been denied privileges, or had privileges revoked, suspended, restricted, reduced, or terminated by the Department of Defense, the Veteran's Administration, or any of their respective components?	☐	☑

Applicant Name: Azra Alexia Wahby MEDICAL BOARD Date: 6/16/13

JUN 27 2013

		YES	NO
21.	Have you ever been diagnosed as having, or have you been treated for, pedophilia, exhibitionism, or voyeurism? If yes, please explain.	☐	☑
22. a)	Within the last ten years, have you been diagnosed with or have you been treated for, bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑
b)	Have you, since attaining the age of eighteen or within the last ten years, whichever period is shorter, been admitted to a hospital or other facility for the treatment of bipolar disorder, schizophrenia, paranoia, or any other psychotic disorder?	☐	☑

If you answered "YES" to any part of this question, please provide details on a separate sheet, including date(s) of diagnosis or treatment, and a description of your present condition. Include the name, current mailing address, and telephone number of each person who treated you, as well as each facility where you received treatment, and the reason for treatment. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

* *

For purposes of questions 23 and 24 the following phrases or words have the following meaning:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments; and
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental, or psychological conditions or disorders, such as but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

		YES	NO
23.	Do you have, or have you been diagnosed as having, a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☑
a)	Are the limitations or impairment caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain.	☐	☑

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

		YES	NO
b)	Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	☐	☑

Applicant Name: Aziza Wahby Date: 6/16/13

MEDICAL BOARD
JUN 27 2013

"Chemical substances" is to be construed to include alcohol, drugs, or medications including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescribers direction, as well as those used illegally.

		YES	NO
24.	Do you use chemical substance(s) which in any way impair or limit your ability to practice medicine with reasonable skill and safety? If yes, please explain.	☐	☑
	a) Are the limitations or impairment caused by your use of chemical substances reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program? If yes, please explain.	☐	☑

If you receive such ongoing treatment or participate in such monitoring program the board will make an individualized assessment of the nature, severity, and duration of the risk associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure. Have each treating physician submit a letter detailing the dates of treatment, diagnosis and prognosis.

	b) Are the limitations or impairments caused by your use of chemical substances reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? if yes, please explain.	☐	☑

* *

For purposes of question 25 the following phrases or words have the following meaning:

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g. heroin or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.

		YES	NO
25.	Are you currently engaged in the illegal use of controlled substances?	☐	☑
	a) If "YES," are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not using illegal controlled substances. If yes, please explain.	☐	☑

Applicant Name: Aziza Wahby Date: 6/16/13

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
AFFIDAVIT AND RELEASE OF APPLICANT

12384 3

The affidavit and release MUST be completed by **ALL** applicants. The form must be notarized in English. Failure of any applicant to submit the affidavit completed and notarized with the application will result in your application being considered as incomplete.

ss STATE OF: FL

COUNTY OF: Pinellas

I, Aziza Wahby, hereby certify under oath that I am the person named in this application for a training certificate in the State of Ohio; that all statements I have made or shall make with respect thereto are true, that I am the original and lawful possessor and person named in the various forms and credentials furnished or to be furnished to this Board with respect to my application; and that all documents, forms, or copies thereof furnished or to be furnished with respect to my application are strictly true in every respect.

I acknowledge that I have read the general information and instructions for all applicants and that I have answered all questions in compliance with these instructions and understand that the fee I submitted is neither refundable nor transferable.

I further state that by filing this application for a training certificate in the State of Ohio, I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness for the practice of medicine or osteopathic medicine. I agree to give any further information which may be required in reference to my past record. I understand that I will not receive a copy of any reports or know their contents and I further understand that the contents of any investigative report will be privileged.

I further understand that my application for a training certificate in the State of Ohio is an ongoing process. I will immediately notify the State Medical Board of Ohio in writing of any changes to the answers to any of the questions contained in the ADDITIONAL INFORMATION section of the application if such a change in an answer is warranted at any time prior to licensure being granted to me by the State Medical Board of Ohio. I further understand that failure to complete this application as requested by the Board within six months can be considered abandonment of any request for a training certificate and that any fee I submitted is neither refundable nor transferable.

I authorize and request every person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency having control of any documents, records and other information pertaining to me to furnish to the State Medical Board of Ohio any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the State Medical Board of Ohio or any of its agents or representatives to inspect and make copies of such documents, records, and other information in connection with this application, subsequent licensure or practice thereunder.

I hereby release, discharge, and exonerate the State Medical Board of Ohio, its agents or representatives and any person, hospital, clinic, governmental agency (local, state, federal or foreign), court, association, institution, or law enforcement agency furnishing information, of any and all liability of every nature and kind arising out of investigation made by the State Medical Board of Ohio. I authorize the State Medical Board of Ohio to release information, material, documents, orders or the like relating to me or to this application to any other governmental agency (local, state, federal or foreign); or to any hospital, nursing home, clinic, health maintenance organization or similar institution; or to any professional association.

I further understand that I must limit my activities under the certificate to the programs of the hospitals or facilities for which the training certificate is issued; and that I may train only under the supervision of the physicians responsible for supervision as part of the internship, residency, or clinical fellowship program.

I further understand that issuance of a training certificate in the State of Ohio will be considered on the truth of the statements and documents contained herein or to be furnished, which if false, can subject me to denial of said certificate.

Signature of Applicant

Subscribed and sworn to before me this 20th day of June 20 13.

Signature of Notary Public

(NOTARY SEAL)

01/12/2016
Date Commission Expires

ALYSSA WILLIS
MY COMMISSION # EE 159430
EXPIRES: January 12, 2016
Bonded Thru Notary Public Underwriters

THIS FORM CANNOT BE FAXED

MEDICAL BOARD
JUN 27 2013

440-585-6141

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://med.ohio.gov/

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
CERTIFICATION OF TRAINING PROGRAM

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by the Ohio training program in which I will be training. Please complete the form and return it directly to the State Medical Board of Ohio at the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT

Name of Applicant: Wahby (Last) Aziza (First) Alexia (Middle) (Suffix (Jr., II))

THIS SECTION TO BE COMPLETED BY OHIO TRAINING PROGRAM

Name of Training Program: UNIVERSITY HOSPITALS REGIONAL HOSPITALS DERMATOLOGY RESIDENCY PROGRAM

Training Program Address: 27100 CHARDON ROAD
Street Address
RICHMOND HTS (City) OH (State) 44143 (Zip Code)

Type of Program (check only one): ☐ Intern ☑ Resident ☐ Clinical Fellow

Specialty (*see reverse side*): DERMATOLOGY

CERTIFICATION DATES - Indicate the month, day and year for both the beginning and ending dates in which the training certificate is to be issued. **THE DATES ARE NOT TO EXCEED ONE YEAR.** If the application is received prior to the date of the appointment, the appointment date will be used. If the application is received after the appointment date, or is not completed until after the appointment date, the completion date will be the date the certificate will become effective.

Dates of Training (***not to exceed one year***): Beginning Date: MO/DAY/YR 07/01/13 Ending Date: MO/DAY/YR 06/30/14

I hereby certify that I have checked the credentials of the above applicant, that the statements, as completed, are true to the best of my knowledge and he/she is of good moral character. I further certify that he/she will limit his/her practice and training within the physical confines of the hospital, or facilities for which the training certificate to practice is sought and that he/she will practice only under the supervision of the attending medical staff of such hospital or facility for which the training certificate to practice is granted. I hereby recommend that the above applicant be granted the certificate herein applied for.

HOSPITAL SEAL

(If hospital has no seal, indicate and have form notarized)

Signature of Medical Director or Program Director

Michael P. Rowane, DO, MS, FAAFP, FAAO
Director of Medical Education
Name (please print) University Hospitals Regional Hospitals

6/24/2013
Date

MEDICAL BOARD
JUN 26 2013

THIS FORM CANNOT BE FAXED

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: http://.med.ohio.gov/

Fax: 614-466-4331

EMPLOYER/TRAINING PROGRAM RECOMMENDATION FORM

Dr. Aziza Wahby
(Please provide the applicant's first and last name.)

is applying for a training certificate in the State of Ohio. We would appreciate your assistance in filling out the following evaluation so that we can process his/her application for the training certificate. **To ensure processing of the physicians application please complete and return this form to the State Medical Board of Ohio at the above address, within two (2) weeks. The form can also be faxed to the Board at (614) 466-4331.** Your immediate attention to this matter will be greatly appreciated by the applicant as well as by us. Information provided is considered confidential under Section 149.43(A)(2)(a), Ohio Revised Code. Thank you for your time and assistance.

(1) How long have you known him/her? 1 YEAR

(2) What is/was your supervisory capacity? Director of Medical Education

(3) At what hospital? Largo Medical Center, Largo, Fl 33770

(4) How would you rate his/her medical knowledge and techniques? Very Good to Excellent

(5) In your opinion is he/she a person of good moral and ethical character? YES

(6) Does he/she work well with peers and medical staff? YES

(7) Does he/she relate well to patients? YES

(8) How is his/her command of the English language (if applicable)? Excellent

(9) Would you recommend him/her for a training certificate to participate in a training program in Ohio? YES

Additional comments, please: (if needed, an extra sheet of paper may be used)

Sincerely,

Gina Bouldware
Licensure Examiner

A N Ottaviani

Signature of Physician

Anthony Ottaviani, DO
Name of Physician (please type or print clearly)

Chief Academic Officer
Position

(727) 588-5204
Telephone number (include area code)

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
RESUME OF ACTIVITIES

List ALL activities in chronological order from the date of medical school graduation to the PRESENT time, using **MONTH** and **YEAR**. *For any non-working time, you MUST state on the resume exactly what your activities were, such as "vacation" or "seeking employment", and indicate your permanent home address for that time period.* If in private practice, indicate the hospitals where you hold or have held privileges and include complete dates and addresses. For any time in which you worked for an "emergency medical group" or did "locum tenens", you must list all hospitals where you worked and include complete dates and addresses. **DO NOT SUBSTITUTE ANY OTHER RESUME OR CV FOR THIS FORM.** Be sure to indicate the percentage of working time spent in clinical and administrative duties. If you require more space, please attach separate sheets.

☐ **Check here if you are a new graduate (within 3 months). You DO NOT need to complete this form.**

From / To	Hospital/University name. Other or non-working activity / Complete Number & Street Address / City, State/Country, Zip Code	Position & Department	%Clinical / %Admin.
From 7 / 12 (Month/Year) To 6 / 13 (Month/Year)	Largo Medical Center 201 W 14th St Largo FL 33770	GME intern	100
From / (Month/Year) To / (Month/Year)			
From / (Month/Year) To / (Month/Year)			
From / (Month/Year) To / (Month/Year)			
From / (Month/Year) To / (Month/Year)			
From / (Month/Year) To / (Month/Year)			

Applicant Name: Date:

State Medical Board of Ohio

30 E. Broad St., 3rd Floor • Columbus, OH 43215-6127 • (614) 466-3934 • Website: www.med.ohio.gov

TRAINING CERTIFICATE - MEDICINE OR OSTEOPATHIC MEDICINE
FORM 1A - VERIFICATION OF MEDICAL EDUCATION
TO BE COMPLETED BY LCME OR AOA ACCREDITED SCHOOLS ONLY

THIS FORM IS NOT TO BE COMPLETED PRIOR TO GRADUATION

I am applying for a training certificate in the State of Ohio. The State Medical Board of Ohio requires that this form be completed by any medical or osteopathic schools I have attended. Please complete this form and return it *directly* to the State Medical Board of Ohio at the above address.

THIS SECTION TO BE COMPLETED BY APPLICANT

Name: Wahby (Last) Aziza (First) (Middle) (Suffix (Jr., II))

Name of Medical/Osteopathic School: Touro Com

Location: New York (City) NY (State)

I hereby authorize the above named medical/osteopathic school to furnish the information below to the State Medical Board of Ohio.

Signature of Applicant 11/5/13 (Date)

THIS SECTION TO BE COMPLETED BY MEDICAL OR OSTEOPATHIC SCHOOL

Our records indicate that Whaby (Last) Aziza (First) (Middle) (Suffix (Jr., II))

attended medical/osteopathic school from 8/11/08 (mo/day/yr) to 6/26/12 (mo/day/yr)

This individual *(check one)*:

☑ was awarded the degree of Doctor of Osteopathic Medicine on 6/26/12 (mo/day/yr)

☐ was not awarded a degree (please attach an explanation)

I, certify that the above information is an accurate account of the above named individual's official records maintained and is true and correct to my knowledge.

AFFIX INSTITUTIONAL SEAL

(If your institution does not have an Official seal, please indicate and have form notarized)

Signature

Kendra Cleveland
Name (please print)

Associate Registrar
Title

11/5/13
Date

THIS FORM CANNOT BE FAXED

License Verification

Data As Of **11/6/2013**

AZIZA ALEXIA WAHBY
LICENSE NUMBER: **UO3185**

Profession
OSTEOPATHIC RESIDENT REGISTRATION

License/Activity Status
NULL AND VOID/

License Expiration Date
6/30/2013

License Original Issue Date
05/15/2012

Discipline on File
NO

Public Complaint
NO

Address of Record
If further information is needed, please contact the Department of Health at (850) 488-0595.

The information on this page is a secure, primary source for license verification provided by The Florida Department of Health, Division of Medical Quality Assurance. This website is maintained by Division staff and is updated immediately upon a change to our licensing and enforcement database.

Date Posted: 2/13/2014 5:33:23 PM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

Address Information

MAIN

2303 Bellfield Ave
apt 1
Cleveland Heights, OH 44106
Cuyahoga County
United States of America
(515) 574-9238
azizawahby@aol.com

License Information

License Number	58.005302
License Name	Aziza Wahby

Fees

Relicensure Fee	$35.00
	========
Total Fees	**$35.00**

TC-Change programs

1. Are you training at the program listed, **OR**, have you been appointed to the program listed for the next training year?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have you been disciplined or notified of an investigation of you by your training program for other than academic performance?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other authority to practice suspended or revoked by any institution or program or have you been placed on probation for any reason other than academic performance?

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.

Date Posted: 3/24/2015 3:55:21 AM

Please review all information you have provided. Click on the "Review" button to change any information given or click on the "I Agree" button to verify that all information posted below is correct and to proceed to payment options.

Please note that knowingly providing false information may result in denial of registration.

License Information

License Number	58.005302
License Name	Aziza Wahby

Fees

Relicensure Fee	$35.00
	========
Total Fees	**$35.00**

TC-Change programs

1. Are you training at the program listed, **OR**, have you been appointed to the program listed for the next training year?

. . . . . YES

Discipline

1. Have you been found guilty of, or pled guilty or no contest to, or received treatment or intervention in lieu of conviction of, a misdemeanor or felony?

. . . . . NO

2. Have you surrendered, consented to limitation of, or to suspension, reprimand or probation concerning, a license to practice any healthcare profession or state or federal privileges to prescribe controlled substances in any jurisdiction other than Ohio?

. . . . . NO

3. Have you been disciplined or notified of an investigation of you by your training program for other than academic performance?

. . . . . NO

4. Has any board, bureau, department, agency, or any other body, including those in Ohio **other than this board,** filed any charges, allegations or complaints against you?

. . . . . NO

5. Have you had any clinical privileges or other authority to practice suspended or revoked by any institution or program or have you been placed on probation for any reason other than academic performance?

. . . . . NO

6. Have you been addicted to or dependent upon alcohol or any chemical substance; or been treated for, or been diagnosed as suffering from, drug or alcohol dependency or abuse?

. . . . . NO

Social Security Number

1.

. . . . . Redacted

I understand that submitting a false, fraudulent, or forged statement or document or omitting a material fact in obtaining licensure may be grounds for disciplinary action against my license.

Under penalty of law, I hereby swear or affirm that the information I have provided in the application is complete and correct, and that I have complied with all criteria for applying on line.